Students with Attentional Disorders: Meeting Their Needs

A Guide for Schools and Families

Rhode Island Department of Education,
Office of Special Needs,
with support from the
Rhode Island Technical Assistance Project

SECOND EDITION - 2001

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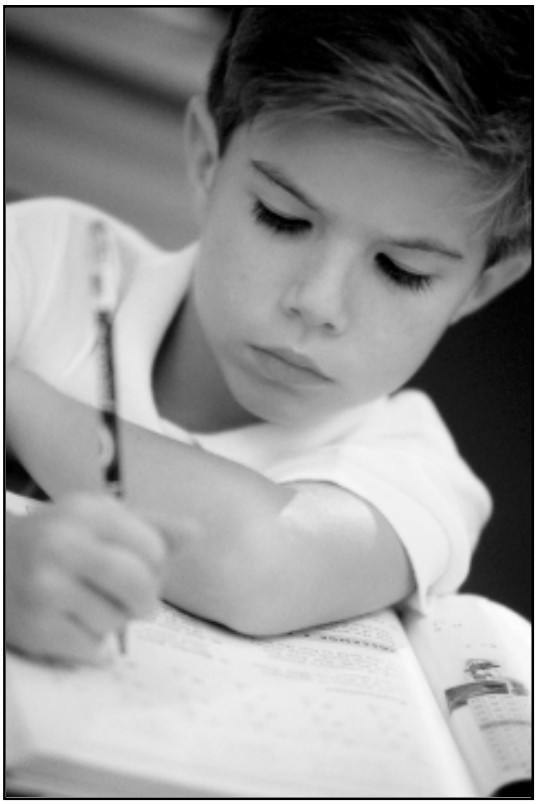

CHAPTER 1

important questions & definitions
INTRODUCTION

QUESTIONS

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l. Why is the Rhode Island Department of Education providing a guide to supporting students with attentional disorders?

Schools and families have long been aware of the particular needs of students with attentional disorders. Over the years, the Department has received many calls from those concerned with the lack of clarity and inconsistency regarding these students.

This guide is intended to provide information for school personnel and parents about appropriate interventions, recommended referral procedures, recommended diagnostic procedures, legal issues as well as recommended resources. This guide is closely linked to state and federal regulations governing special education and Section 504 of the Rehabilitation Act. This guide goes beyond these, however, and includes best practices.

2. *What is some important information about students with attentional disorders?*

The cognitive, behavioral and sustained attention difficulties characterized as attentional disorders are found in 3 to 6% of school age students. Most reports indicate a ratio of 3 or 4 boys to each girl; however, researchers are beginning to question whether girls have been underrepresented. These difficulties begin early in life and affect the students in multiple areas on a daily basis. Students with attentional difficulties typically experience difficulty at home, school and in the community. These students form a heterogeneous population with considerable variation in the degree of their symptoms. These symptoms, with which they struggle, are found in the everyday situations, tasks, relationships, as well as in the additional disorders that arise in association with their difficulties. Some students with attentional disorders have difficulty with peer interactions, with academic achievement and with general adjustment, most especially experiencing low self-esteem. Their performance is uneven and unpredictable from time to time, situation to situation, task to task, person to person. This often leads to the erroneous belief that these are psychologically based deficits. Attentional disorders are no longer considered to be caused by faulty child-rearing or by other social emotional factors. They are developmental disorders with a strong biological/neurological component often involving a hereditary component.

While there is no specific cure for an attentional disorder, its symptoms can be managed using a multidisciplinary, multi-treatment model including such interventions as specialized behavior management, educational intervention, cognitive/motivational training, social skills training, problem-solving training and pharmacological management. However, some individuals do mature out of the attentional disorders while others develop effective coping skills.

3. *Are all students with attentional disorders entitled to special education services or other services within the school setting?*

No student is automatically entitled to special education services because of a diagnosis. However, students with attentional disorders may receive special education services if they also meet the criteria for one of the established disability categories; the most common categories are learning disability, behavior disorder or other health impaired. Students whose characteristics do not meet special education criteria may come under the protection of Section 504 of the Rehabilitation Act and be entitled to a plan that provides needed modifications to the regular education setting. (See Chapter 5 for additional information.)

There is general agreement that the best place to serve students with attention difficulties is in a natural school setting such as an age appropriate regular class-

room in a neighborhood school. For students with attentional disorders, learning to succeed in the natural setting is particularly important; and that setting is where even supplementary services can be best delivered to them. Remember that attentional disorders are not neccessarily cured, and students need to learn coping strategies for the "real" world.

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4. *Do all students with attentional disorders benefit from the same approach?*

   Although certain interventions are commonly used to support students with attentional disorders, each student has particular, specific needs that require an individualized plan of support. In considering the compilation of interventions offered in this guide, care must be taken to match the student's individual needs with particular approaches, to monitor carefully the effects of using any intervention and to be prepared to modify an approach promptly as indicated by the student's response.

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5. *How are students with attentional disorders diagnosed?*

   There is no single method for diagnosing an attentional disorder. Identification and evaluation of attentional disorders require a multidisciplinary approach involving parents, teachers, physicians as well as educational and mental health professionals. Evaluation often includes educational and intelligence testing, behavioral inventories and checklists, psychological examination to rule in or out other disabilities or disorders. Once goals and interventions have been identified, they will require frequent review and revision because of the variability in the developmental course of students with attentional disorders. While there may be no "cure" for this disorder, some people do mature and cease to show the symptoms. For others, a commitment to long-term management is required with the emphasis on developing in the child the coping skills needed to maximize his/her potential. Optimal development and structured, supportive environments promoting good coping skills which lead ultimately to success in school and community are the goals for all children.

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6. *Do students with attentional disorders often have other diagnoses?*

   Many students with attentional disorders also meet the diagnostic criteria for other psychiatric and/or learning disorders. The term for two or more disorders occurring together is comorbidity. The disorders found to occur significantly more in students with attentional disorders than in students without attentional disorders include: mood disorders, anxiety disorders, tic disorders, disruptive behavior disorders, learning and communication disorders, visual perceptual motor disorders, sensory integration deficit, substance abuse, obsessive compulsive disorders, and sleep

disorders. Students with comorbid disorders are likely to experience greater difficulty in school, in the family, and in the community. Given the comorbidity of attentional disorders with other disorders no evaluation of attention disorders can be considered complete without screening for possible comorbidities. Comorbid symptoms and/or diagnoses need to be taken into account in planning and treatment.

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7. *What is the role of the regular education teacher?*

   The regular education teacher is the first line of defense in helping students with attentional disorder. The teaching strategies presented in this manual are intended for use by regular education teachers as well as by special education teachers. Given the complexity of most students with attentional disorders, professional development of both regular and special education teachers is essential.

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8. *What is the role of families in successful support plans for students with attentional disorders?*

   Family centered interventions are extremely important to the success of students with attentional disorders. Interventions can only be implemented and maintained if parents and school personnel establish these interventions cooperatively and communicate regularly about their effectiveness. It is particularly important that all adults are consistent in their interactions with students with attentional disorders. Families can provide valuable information on the behavior of students outside of school and on interventions that have been effective. They can also report on relationships and the atmosphere at home and in the community, important factors in a support plan. Families and school staff can share information on support services and professional resources.

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9. *Is there anything positive about having an attentional disorder?*

   There can be many positive characteristics associated with the way that students with attentional disorders process their worlds. Many students with attentional disorders display great creativity, the ability to examine the world from multiple perspectives, great sociability, high energy, great enthusiasm and spontaneity. History is replete with examples of people with attentional disorders who have been very successful. This manual is designed to help those with attentional disorders to maximize their potential and to minimize their limitations. We hope that you find it helpful.

DEFINITIONS

l. Attentional Disorders

Many terms have been used over the years to refer to students who have problems with attentiveness, distractibility, impulsivity and even hyperactivity. In identifying, diagnosing and treating attentional disorders we have found it helpful to refer to a functional definition that centers around a list of core symptoms. Students with attentional disorders are likely to have difficulty in some or all of these areas:

- Remaining on task
- Controlling motor activity and arousal
- Controlling impulses
- Tolerating frustration and waiting
- Following rules, routines, & instructions
- Responding to typical disciplinary and motivational systems
- Organizing and sequencing
- Managing boredom
- Seeking stimulation
- Interacting with peers

While many of the problems identified above are manifested by some students, in the classroom these students are seen as quiet or passive in nature. They may be overlooked in the classroom as having attentional problems. The current psychiatric nosology may be confusing, particularly as it denotes those with an attentional disorder without hyperactivity as having the diagnosis Attention Deficit Hyperactivity Disorder - Predominantly Inattentive Type. Even though the child is given the "ADD" diagnosis, it may not include hyperactive or impulsive behavior. Other children do show evidence of hyperactivity, impulsivity and disinhibition and they may have a diagnosis of ADHD–Hyperactive-Impulsive Type or ADHD–Combined Type where all elements are found equally.

In this manual we will present a working definition of attentional disorders based on diagnostic procedures and instruments. Answering the following questions allows one to define attentional disorders specific to each student.

1. Does the student meet the criteria of the DSM-IV (see Appendix A)?
2. Have other diagnoses (i.e., depression, obsessive compulsive disorder, anxiety, substance abuse, etc.) been ruled out?
3. Does the student receive elevated scores on attentional rating scales in comparison to students of the same age and sex?
4. Does the student demonstrate difficulty in two or more settings?
5. Does the student receive elevated scores during systematic behavioral observation at school, at home or in an office setting?
6. Does the student demonstrate difficulty on specific psychological and neuropsychological tests measuring verbal, nonverbal, visual-motor, fine-motor, gross-motor, executive functions, vigilance, and attentional skills?

7. Have the symptoms or difficulties been present prior to age seven?

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2. Comorbidities

The term for two or more disorders occurring together is comorbidity. The disorders found to occur significantly more in students with attentional disorders include: mood disorders, anxiety disorders, disruptive behavior disorders, learning and communication disorders, visual perceptual motor disorders, sensory integration deficit, substance abuse, tic disorders, obsessive compulsive disorder, and sleep disorders.

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3. Teams

There are references to a number of "teams" in this document.

Teacher Support Team (TST):
Recent legislation, Article 23, has linked student intervention teams to the school improvement process. To signify and underscore the focus of the legislation, the team has been named the Teacher Support Team (TST). This process was formerly called the Classroom Alternatives Support Team (CAST). The newly named Teacher Support Team provides collaborative support to teachers as they develop alternatives for students experiencing learning and behavior difficulties in the classroom.

The TST is a group of colleagues within each school who join the problem solving efforts of the teacher. While this team primarily consists of regular education staff, specialized personnel can be called on to provide assistance to the team as needed. The TST works with individual teachers requesting assistance in a systematic, collaborative problem solving process. The team provides direct support to teachers, and indirect support to students.

Section 504 Team:
If a student is referred to the Section 504 Team, a qualified group of people must determine whether an evaluation under Section 504 guidelines should be conducted, and what evaluations are needed. If a student requires an evaluation under Section 504, a qualified group of people must conduct or supervise it. If it has been indicated by the results of an evaluation that an accommodation plan is needed to serve the student, it must be prepared by a qualified group of persons. Ensure that the placement decision is made by a group of persons, including persons knowledgeable about the child, the meaning of the evaluation data, and the placement options [504 Regulations – Section 104.35 (c)(3)].

Evaluation Team for Special Education:
The Evaluation Team consists of a team of qualified professionals and the parent.

Qualified professionals are individuals who have met state approved or state recognized certification or licensing in the area in which they are providing special education and related services. Within ten (10) school days of the receipt of a referral for special education services a team of qualified professionals including the parent, individuals that comprise the IEP team and other qualified professionals, as appropriate, known as the Evaluation Team, meet to determine if a special education evaluation is needed. Once the evaluations have been completed, the Evaluation Team will determine whether the child is a child with a disability and is need of special education and related services. For more detailed information on the Evaluation Team, see RI Regulations 300.531.

IEP Team:
The Individual Education Program (IEP) must be developed by a team of individuals which minimally includes the parent, the regular education teacher, the special education teacher, the school district representative and the student, if appropriate. However, if transition goals are to be discussed, the student must be invited. At least one member of the IEP Team must be someone who can interpret the instructional implications of evaluation results.

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4. Family Involvement

The involvement of families is of primary importance to the success of efforts made on behalf of students. When the linkages between schools and families are strong, families feel valued and school personnel feel supported. Such linkages are of great importance when students have attentional disorders because there is a strong need to fine tune the coordination, even down to using the same words, at home and in school.

"Involvement" means two-way communication, awareness and respect. In order to enhance the ability of both families and schools to participate in such a partnership, they both need to offer, to seek out and to welcome information about the student in his/her total environment. It is far easier to build and maintain family/school involvement when it is begun early and when it takes into account the family's interests. Along the way partnership will be facilitated when:

(A) families receive clear and concise explanations of procedures, of interventions, of their rights and sources of support

(B) schools tap the knowledge base that families have about students and consider the goals that are meaningful to students and their families.

CHAPTER 2

home and school based interventions

The State of Rhode Island is on the cutting edge in the way students with attentional disorders are supported. This section of the manual is intended to:

1. highlight the strategies with the greatest empirical support
2. identify additional resources for teachers, other school personnel and families

Recent research supports the efficacy of stimulants and psycho-social treatments for attentional disorders. For many students, stimulant medication which affects attention is sufficient. But, since most students have other co-existing problems (co-morbidities) in addition to attention, a combination of medication and other educational and psychosocial interventions are necessary. Psychosocial interventions include behavioral strategies such as contingency management (e.g., point or token reward systems, timeout, response cost) and cognitive-behavioral treatment (e.g., self-monitoring, self-instruction, self-reinforcement, social problem solving). Contingency management, in particular, has produced beneficial effects in some children. Response cost may be particularly important for motivating youngsters with ADHD whose performance can be enhanced by the addition of prudent negative consequences to positive reinforcement programs. Response cost involves the loss of previously earned reinforcers, contingent upon the display of a

target behavior deemed unacceptable (e.g., disruption, aggression). Such a program needs to be supplemented by direct reinforcement of alternative behavior. There is less evidence for the efficacy of cognitive-behavioral interventions for purely attentional concerns, but they are very effective for some co-morbidities, such as obsessive compulsive tendencies.

Twenty of the most common home and school related difficulties of students with attentional disorders:

1. sustaining attention
2. impulsivity
3. distractibility
4. compliance with requests and rules
5. following directions
6. organization
7. sequencing
8. motor coordination
9. disruption
10. interruption
11. making transitions
12. self-esteem
13. peer interaction
14. language processing
15. language output
16. written work
17. learning from text
18. studying for tests
19. follow-through on independent work
20. doing homework

On the following pages a chart identifies some intervention strategies for each of the above.

Behavior	Strategies
1. Attention	1. provide specific rewards for attending 2. break tasks down into small units and give student breaks 3. cue student to refocus 4. make task to be done of high stimulus value 5. use student's name in lesson presentation 6. actively involve student during lesson presentation (e.g., let him /her write key words on board)
2. Impulsiveness	1. teach "stop, look, think." 2. reward for decreasing impulsive errors 3. encourage self-talk and self-reinforcement for stopping and thinking 4. establish cues for waiting, slowing down
3. Distractibility	1. seat near teacher with back to rest of class 2. surround with good role models 3. avoid highly distracting stimuli that take student's attention away from task (e.g., window looking out to playground) 4. maximize stimulation level of what student is supposed to attend to (highlighting, drawing borders around parts of page to be read, visual presentation to accompany auditory) 5. allow student to use headphones to play music to block out auditory distractions
4. Compliance	1. remind of rule/policy 2. tell what to do instead 3. give time to comply 4. have a known consequence ready for non-compliance 5. reinforce compliance 6. use indirect, depersonalized requests 7. give choices 8. pick your battles 9. stay cool and do not get too emotional
5. Following Directions	1. be clear, concise 2. make sure directions are understood 3. have a known consequence for not following direction 4. alert that a change is coming 5. reinforce successful following of directions 6. use notes and other environmental cues as reminders 7. ask the student to repeat directions

6. Organization	1. break a task down into its sub-tasks 2. provide cues as to what is next 3. monitor work frequently; have student "check-in" 4. make prioritized to-do lists with student 5. make a daily schedule and keep it visible 6. teach how to organize materials (e.g., how to place book, paper, pencil, eraser on desktop) 7. have a system (e.g., color codes) to keep classroom materials organized
7. Sequencing	1. practice breaking a task down into its components 2. emphasize putting things in order (e.g., events, information, objects) 3. ask to make predictions or "what's next" 4. point out sequence and patterns in daily living
8. Motor ineptness	1. teach, re-teach and practice motor skills 2. minimize motor requirements such as copying 3. give extra time 4. set realistic and mutually agreed upon expectations for neatness 5. teach and cue student to go slower 6. teach student to proofread, type, use word processor
9. Disruption	1. set up a response cost system to reinforce not disrupting 2. establish a secret cue to alert student when he's/she's being disruptive and reinforce desisting 3. keep student busy so he/she will not have free time 4. reinforce other children for ignoring disruptive behavior 5. set up a self-monitoring, self-reinforcement system for disrupting
10. Interruption	1. set up a response cost system to reinforce not interrupting 2. establish a secret cue to alter student when he's/she's interrupting 3. call on student and let him/her speak before he/she can interrupt 4. teach other students how to respond to being interrupted
11. Making Transitions	1. give warning, prepare student for the move 2. allow a little extra time to make the transition 3. be sure student knows what comes next 4. provide visual cues (e.g., signs, color markers) 5. provide a predictable routine 6. when going from highly stimulating, unstructured situations (e.g., recess) to less stimulating situations (e.g., seat work) allow student to wind down gradually (e.g., sharpen pencil, erase board)

12. Self-esteem	1. reinforce appropriate behavior whenever, or whatever 2. teach student to reinforce him/herself 3. provide frequent feedback on how well he/she is doing 4. expect that he/she will do better some days than others 5. find and cultivate an area of expertise
13. Peer Interactions	1. teach social skills 2. review social interactions 3. evaluate alternatives and plan for future situations 4. pair student with good role models
14. Language Processing	1. maintain eye contact 2. keep message clear and concise 3. repeat 4. have student repeat message 5. reinforce verbal information with written information 6. use lots of examples and relate new materials to student's experiential base 7. provide an overview of lesson before beginning 8. alert student to what is important, revelant, to be remembered
15. Language Output	1. give student extra time to say what he/she wants 2. help structure student's language (e.g., ask questions, cue to stop repeating) 3. when student cannot find a word, give him initial sound 4. ask specific questions instead of general, open-ended questions
16. Written work	1. reduce volume of work required 2. permit dictation, typing and word processing 3. teach proof reading 4. construct a work plan with the student 5. provide questions to be answered as a way of organizing material 6. teach to go back and edit and condense
17. Learning from text	1. highlight information to be learned 2. preview the material 3. teach to identify questions after previewing what he/she is to read 4. demonstrate to student how new material relates to previously learned material

18. Studying for tests	1. make sure student knows what is to be done 2. prepare an outline with student of material for test 3. identify main ideas with student 4. put one bit of information on each index card and have student study cards only 5. show student what does not need to be reviewed 6. put information to be learned in a sequence and have student study it in that order 7. set realistic expectations with student
19. Following through on independent work	1. make sure student knows what is to be done 2. break task down into components and put them in sequence 3. have a student check in periodically 4. give only one task at a time 5. set up a school-home note program 6. teach student to self-monitor and self-reinforce
20. Doing homework	1. make sure student knows what is to be done 2. make sure student takes home all necessary materials 3. set up a school-home note program 4. arrange contingency plan for completing homework 5. set realistic expectations for how much homework will be done

KEY POINTS IN DESIGNING INTERVENTION PLANS

1. Combined behavioral and pharmacological interventions are often necessary.

2. In designing behavior management programs, positive reinforcement (e.g., praise, tokens, and points) is rarely sufficient by itself to maintain improved behavior. Effective programs are complex, combining multiple strategies including response cost and environmental restructuring.

3. Reinforcers must be very powerful to the student; effective reinforcers are often tangible; the frequency must be high, and reinforcement must occur immediately after the desired behavior occurs.

4. Consequences must also be delivered immediately after undesired behaviors occur.

5. Manipulation, restructuring, rearrangement of the student's environment are often very effective especially when combined with behavior management. The "passive" management strategies include modifying tasks, re-arranging the physical environment, cueing, giving choices and teaching organizational skills.

6. A multi-modal approach is necessary, involving a treatment team made up of families, teachers, physicians as well as educational and mental health professionals using a variety of treatment modalities.

7. Intervention planning will need to take a long-term perspective since attentional disorders may require on-going management until the student has developed sufficient coping skills. The developmental processes, thought to underlie attentional disorders, may only be complete in adulthood for some individuals.

8. Regular and frequent reviews and revisions of the intervention plan will be necessary due to the idiosyncratic responses students with attentional disorders have to management and motivational systems and due to the unpredictability and unevenness of their development, or to the presence of other comorbid conditions.

9. At all times, it must be remembered that the performance of students with attentional disorders is inconsistent, varying from time to time, situation to situation, task to task, person to person. This requires contingency planning and also patience in making careful observations and in being willing to make changes.

10. It must be remembered that students with attentional disorders tend to be slow maturers across the board, but particularly in their social and emotional development, thus often needing to be treated like chronologically younger children.

Intervention Strategies for Elementary and Secondary Students

The strategies identified in this section are supported by empirical research. While they are especially effective for students with attentional disorders, they have been demonstrated to be effective with all students. Therefore, it is recommended that regular education teachers should consider using these strategies in their classrooms on a regular basis. It should also be considered that not all students with an attentional deficit hyperactivity disorder diagnosis will need all the interventions listed. Each student should have an individualized intervention plan.

INTERVENTIONS FOR ELEMENTARY STUDENTS

Environmental and curricular based strategies to support children with attentional disorders at school and home

1.

Students with attentional disorders are frequently unfocused.

To help students with attentional disorders when they are unfocused:

School

- Allow them some form of supplementary activitiy that is nondisruptive (e.g., carrying worry beads, rubbing feet on the floor, using squeezeball)
- Allow them some form of supplementary auditory activity that would be nondisruptive in completing the task (e.g., using earphones to listen to tapes while doing seatwork)
- Provide opportunities for appropriate movement
- Interact frequently with them verbally and physically
- Actively involve them by calling on them, using their names, having them write key words on the board, etc.
- Give them colored pencils and let them change colors as they do worksheets

Home

- Allow them some form of supplementary activitiy that is nondisruptive (e.g., carrying worry beads in the pockets, taking an etch-a-sketch in the car)
- Allow them some form of supplementary auditory activity that would be nondisruptive in completing the task (e.g., using earphones to listen to tapes while doing homework or riding in car)
- Interact frequently with them verbally and physically
- Increase the drama when interacting with them (e.g., be silly or outrageous)
- Let them move around (e.g., between courses during dinner)
- Keep movement restrictions to a minimum (e.g., tolerating squirming as long as they stay in the chair)

School

- Give them something to do when they have to wait
- Reduce the amount of repetitive work to be done
- Give them short tasks and vary the tasks
- Encourage them to develop mental images of the materials being presented and ask them about these images
- Encourage them to draw small relevant pictures in the margins while reading and/ or to write summaries of paragraphs
- Increase the "drama" of teacher presentations
- Use multi-sensory presentations, being sure that the interesting stimuli that are added (e.g., pictures or sounds) are revelant to the important concepts
- Use role playing to act out key concepts or events
- Use game-like activities to reinforce learning
- Allow them to work with peer tutors that will help them maintain attention to learning

Home

- Give them something to do when they have to wait
- Give them short tasks to do (e.g., put out just the silverware)
- Vary their activities (e.g., plan three short activities not one long one)

2.

Students with attentional disorders are drawn to the powerful or salient stimuli which may not be what they are supposed to be doing.

To help students with attentional disorders pay attention to what is relevant:

School

- Make what is revelant also highly stimulating by:
  - making it louder or brighter or funnier
  - varying speed of presentation
  - decorating ordinary worksheets
  - being dramatic
  - being very positive and enthusiastic
- Keep the pace of lesson presentations moving, minimizing pauses
- Actively involve them during presentations to keep them interested
- Be physically near them when you are what they are to be attending to
- Move about the room to have access to them for cueing and to make use of proximity control
- Develop a set of silent signals to cue them about what they're supposed to be doing
- Seat them near good role models
- Keep a place free of extraneous auditory and visual stimuli for them to go with important, stimulating tasks

Home

- Make what is relevant also stimulating by:
  - making it louder or brighter or funnier
  - varying speed of presentation
  - being dramatic
  - being very positive and enthusiastic
- Remove or reduce distracting stimulation (e.g., turn off the television when you're going over tomorrow's schedule)
- Be physically near them when you are what they should be attending to
- Keep the pace moving of direction giving or explaining, minimizing pauses
- Actively involve them in explanations by asking them their opinions or suggestions
- Develop a set of silent signals to cue them about what they are supposed to be doing (e.g., one nod means lower your voice)

School

- Supplement the stimulation when tasks/ materials aren't inherently stimulating (e.g., by allowing earphones to listen to music, by encouraging self-talk, by encouraging experimentation with different kinds of writing)
- Give them several spaces at which they can work and allow them to move from one place to another
- Reinforce attending to what is revelant
- Use response cost when they are not paying attention to what is revelant

Home

- Reinforce them when they are paying attention to what is relevant
- Use response cost when they are not paying attention to what is relevant

3.

Students with attentional disorders have difficulty following rules and complying with requests.

To help students with attentional disorders follow rules and be more compliant:

School

- Make sure they understand the request
- Make sure they can remember the rule and know what it means
- Review with them ahead of time what rules are in effect
- Provide cues (such as a list of rules) to remind them of the requirements
- Give a request in a firm but pleasant voice, wait five seconds and then tell student what the consequence will be for non-compliance
- State requests indirectly (e.g., "the schedule says it is clean-up time")
- Reinforce compliance
- Use response cost or time out of noncompliance

Home

- Make sure they understand the request (e.g., restate it in their own words)
- Make sure they can remember the rules (e.g., ask them to tell you the rules)
- Review with them ahead of time what rules will be in effect in any given situation
- Provide cues (such as a list of rules) to remind them of the requirements
- Give a request in a firm but pleasant voice, wait five seconds and then tell child what the consequence will be for non-compliance
- State requests indirectly (e.g., "the clock says it is time for bed")
- Reinforce compliance
- Use response cost or time out for noncompliance
- Be consistent

4.

Students with attentional disorders have difficulty with transitions.

To help students with attentional disorders handle transitions:

School

- Warn them ahead of time
- Set timer to show them when they will have to finish or stop
- Tell them where they are going, what is happening next (with young students, you might have to use pictures)
- Make what is coming next appear interesting
- Give them something to do during transitions (e.g., hold the door, count the students as they go by, collect things, copy something from the board)
- Keep in contact with them during transitions and cue them to behave appropriately
- Reinforce successful transitioning
- Use response cost or time out for inappropriate behavior

Home

- Warn them ahead of time, before they will actually have to change (e.g., in five minutes, it is time to put away the legos)
- Set a timer to show them when they will have to finish
- Tell them where they are going, what is happening next (with young children, you might have to use pictures)
- Make what is coming next appear interesting
- Give them choices as to what to do next
- Reinforce successful transitioning
- Use response cost or time out for inappropriate behavior

5.

Students with attentional disorders have difficulty with time.

To help students with attentional disorders handle time:

School

- Be sure they have watches and clocks (preferably analog) and kitchen timers
- Decide with them how much time to allocate to the different segments of a task
- Cue them about how much time has passed and how much time is left
- Check in frequently about their use of time
- Do not make them wait too long
- Give short but reasonable advance notice
- Provide them with clear criteria for acceptable, completed work
- Show them examples of acceptable work
- Reinforce them by having them check over their work before handing it in
- Teach them procedures for improving accuracy and quality (e.g., checking for errors, proofing work with a peer, etc.)
- Avoid encouraging unnecessary speed
- Monitor accuracy and quality of their work
- Check work promptly so they can revise it
- Promote use of computers

Home

- Be sure they have watches and clocks (preferably analog) and kitchen timers
- Decide with them how much time to allocate to the different segments of a task
- Cue them about how much time has passed and how much time is left
- Check in frequently about their use of time
- Do not make them wait too long
- Give short but reasonable advance notice
- Provide them with clear criteria for acceptable, completed work
- Show them examples of acceptable work or completed tasks (e.g., a picture of their clean room)
- Reinforce them by having them check over their work before saying it is done
- Teach them procedures for improving accuracy and quality (e.g., checking for errors, proofing work with a parent, etc.)
- Monitor their work for accuracy and quality, reinforce accuracy and quality and not necessarily speed

6.

The performance of students with attentional disorders deteriorates with repetition.

To help students with attentional disorders handle repetitions:

School

- Plan the most important work in the morning
- Keep presentations/tasks brief
- Break down long tasks into segments
- Provide a variety of different activities during each lesson
- Divide worksheets into segments by folding them or blocking them using different colored borders
- Have students check in after completing each segment
- Shorten assignments (if student can demonstrate mastery with 10 or 20 examples, do not require more, or go back at a later time and give the additional examples)
- Give frequent short quizzes and avoid long tests

Home

- Plan the most important activity in the morning
- Keep tasks and activities short, ending them before they will be ruined
- Break long task and activities down into steps, taking breaks and offering reinforcements between steps
- Provide a variety of short activities instead of a long one; try to build variety into repetitive activities (e.g., fold half the towels one way and half another way)
- Have children take breaks and check in frequently for reinforcement when doing long tasks

7.

Students with attentional disorders tend to "go on and off task."

To help students with attentional disorders who "go on and off task":

School

- Be accepting that this is their style
- Teach them to recognize when they are "going off-task" and make some sort of mark, if possible
- Teach them how to get themselves back on task (e.g., by reviewing quickly what they have done, by going back to the directions)
- Teach them to reinforce themselves when they get back on task
- Have them use paper stripes or rulers to move down the page as they read each line
- Have them read aloud or to themselves very quietly to help them maintain their place
- Be vigilant to spot when they are going off task and cue them to go back on task
- Use cues that alert them to when it is important to be on task (e.g., by using verbal cues such as, "Now this is really important.")

Home

- Be accepting that this is their style
- Teach them to recognize when they are "going off-task" and make some sort of mark so they will know where to start up again
- Teach them how to get themselves back on task (e.g., by reviewing quickly what they have done, by going back to the directions)
- Teach them to reinforce themselves when they get back on task
- Help them learn how to have more than one project or activity going at one time and be able to switch between them without becoming distracted
- Be vigilant to spot when they are going off task and cue them to go back on task
- Use cues that alert them to when it is important to be on task (e.g., by using verbal cues such as, "Now this is really important.")

8.

Students with attentional disorders often have difficulty identifying what is important and what they should be paying attention to.

To help students with attentional disorders identify what is important and what they should be attending to:

School

- Accept that this is how they are
- Provide an outline list of keywords or concepts
- Underline key words or key vocabulary
- Have students underline key words
- Have students develop outlines
- Draw borders around important information
- Cue them verbally to what is important
- Remind them that the important material is the information that is repeated
- Teach them that what is important is usually identified (e.g., in a text it is in bold type)
- Send them short notes about the important things that are going on
- Give additional presentations of important materials by repeating the original presentation, repeating main points, giving additional examples, modeling skills in different contexts, etc.

Home

- Accept that this is how they are
- Cue them to what's important (e.g., "what is important is the man in the pulpit not the lady at the organ")
- Remind them of what they have forgotten
- Highlight what is important (e.g., use different colored bins for different kinds of toys)
- Say what is important in different ways

9.

Students with attentional disorders have difficulty with organization and sequencing.

To help students with attentional disorders with sequencing and organization:

School

- Provide outlines, lists of steps
- Cue them verbally by saying, "first we will do this, next we will do that", etc.
- Establish and post a daily routine schedule
- Write on the board any change in the usual schedule
- Alert them to changes and explain this is a one time change
- Provide extra support and feedback when there are changes
- Try to minimize changes in their schedules
- Review frequently where they are in the routine
- Provide outlines or study guides emphasizing the order of events or the steps in a task
- Have them prepare their own guides or lists in writing or on tape

Home

- Teach the order in which they should do something
- Cue them verbally saying, "first we will do this, then we will do that"
- Give them cues to remind them of the order (e.g., a set of index cards with the steps to follow in making a bed)
- Establish a daily routine and post the schedule
- Alert children to any changes in the schedule and explain that these are one time changes
- Provide extra support and reminders when there are changes
- Review frequently where they are in the routine ("look you have done four steps, three more")
- Help them organize their spaces (e.g., using plastic containers for toys, school supplies)

School

- Develop checklists that stay on the desk or are taped to assignments identifying what needs to be done
- Schedule short, frequent check-ins to be sure they are following the correct sequence
- Help them organize their desks
- Do a diagram of how their desks should be organized
- Do a diagram of how their papers should look (e.g., where the name goes, how the margins should look)
- Allow time at the end of the day to collect things to go home and organize their desks for the next day
- Develop checklists to use at various times (e.g., before going to gym or going home) to organize materials
- Reinforce following a sequence and knowing the order
- Use response cost for being disorganized, unprepared or not following a sequence

Home

- Do diagrams of how spaces should look (e.g., their bookshelves or their desks when they sit down to do homework)
- Allow time at the end of the day to organize things for the next day
- Do activities with them such as cooking that have specific sequences
- Review with them the rules for games they play
- Develop check lists to use at various times (e.g., before going to scouts or to swimming lessons)
- Reinforce being prepared and organized
- Reinforce knowing the order and sticking to a sequence
- Use response cost for being disorganized or unprepared
- Use response cost for not following a sequence

10.

Students with attentional disorders do not tend to generalize.

To help students with attentional disorders generalize:

School

- Prepare them for the fact that the same rules, procedures, strategies apply
- Point out how situations, tasks, materials are similar
- Reinforce generalizing

Home

- Teach them that the same rules, procedures, strategies apply in similar circumstances
- Point out how situations, tasks, materials are similar (e.g., “No one, neither other children nor adults, likes it when they are laughed at for making a mistake.”)
- Reinforce generalizing (e.g., “Great, you figured out this puzzle is just like the one we did yesterday.”)

11.

Students with attentional disorders have behavior, performance, functioning, and knowledge levels which are variable.

To help students with attentional disorders:

School

- Be aware of the fact that students with attentional disorders are inconsistent
- Be consistent yourself especially in cueing and giving consequences

Home

- Be aware of the fact that they are inconsistent
- Be consistent yourself

12.

Students with attentional disorders have idiosyncratic responses to consequences:

To help students increase positive behavior:

School

- Select a specific behavior to reinforce such as raising your hand when you have a question rather than a general category of behavior such as being polite
- Select a reinforcer that is readily available, can be delivered immediately following the desired behavior, and can be used frequently such as stickers or points
- Begin with tangible reinforcers and move toward social reinforcers
- Have available a menu of reinforcers such as earning ten points today that you may trade for extra computer time, game time with a friend, etc.
- Reinforce as quickly as possible after the desired behavior occurs
- Tell the student about the reinforcement plan
- Describe the behavior that is being reinforced (e.g., "You earned ten points for getting all the math problems correct.")

Home

- Select a specific behavior to reinforce such as putting all the puzzles on the shelf rather then a general category of behavior such as putting all the toys away
- Select a reinforcer that is readily available, can be delivered immediately following the desired behavior, and can be used frequently such as stickers or points
- Begin with tangible reinforcers and move toward social reinforcers
- Have available a menu of reinforcers such as earning ten points today that you may trade for an extra half hour of TV, the privilege to choose the dessert for tonight, etc.
- Reinforce as quickly as possible after the desired behavior occurs
- Tell the student about the reinforcement plan
- Describe the behavior that is being reinforced (e.g., "You earned a sticker on the chart because you were dressed by 7:30.")

School

- Gradually decrease the number of reinforcers given
- Give frequent non-contingent positive reinforcement (e.g., “Here is an extra sticker because you are trying hard to listen to my directions.”)
- When student engages in inappropriate behavior, first remind student what he/she is supposed to be doing and immediately reinforce the change
- If student does not change behavior, consider using timeout (e.g., have student sit at desk with no interaction or remove student from group)
- If student does not change behavior, consider using response cost (e.g., student loses points, a privilege, or an opportunity)
- Eliminate stimuli that might be eliciting the inappropriate behavior (e.g., having to stand for a long time in line)
- Explain the plan for use of timeout and response cost to the student

Home

- Gradually decrease the number of reinforcers given
- Give frequent non-contingent positive reinforcement (e.g., “Here is an extra sticker because you are sitting quietly while I drive.”)
- When student engages in inappropriate behavior, first remind student what he/she is supposed to be doing and immediately reinforce change
- If student does not change behavior, consider using timeout (e.g., turn off the TV for five minutes or remove student from the table)
- If student does not change behavior, consider using response cost (e.g., student loses a sticker, a privilege, or an opportunity)
- Eliminate stimuli that might be eliciting the inappropriate behavior (e.g., turn off television during study time)
- Explain the plan for use of timeout and response cost to the student

INTERVENTIONS FOR SECONDARY STUDENTS

It may appear to those of you who have teenagers of your own or work with teenagers, that all teenagers could be diagnosed with ADHD at one time or another. Many teens appear disorganized, depressed, do not focus consistently and have difficulty with rules. To clearly understand what ADHD is, it helps to understand what it is not. It is not the average teen bursting with energy, or the one who occasionally appears depressed, restless or distracted. Not every adolescent who is hyperactive, inattentive, impulsive or sad has ADHD. Most adolescents exhibit these behaviors at different times during the teen years. It is very important to first rule out other causes such as a learning disorder, a physical ailment, substance abuse, conduct problems or disruptive or unresponsive behavior due to anxiety, depression, grief or loss connected to family dysfunction, divorce or death.

In making a determination, it is important to consider all possible causes for these behaviors. Professionals will consider the age at which these behaviors first appeared and whether they are as frequent or severe as behaviors found in others of the same age. Also, functional impairment, that is to say, how consistent or how severe an impact these behaviors have on the daily functioning of the adolescent must be considered. The behaviors must interfere with at least two areas of the person's life, such as school, home, work or social relationships. Someone whose school work or friendships are not impaired by the behaviors might not be diagnosed with ADHD, nor would an adolescent who seems overly active or bored and distracted at school but functions well elsewhere. ADHD must be looked at on a continuum and, therefore, you may see symptoms ranging from mild to severe, and these symptoms may change.

During adolescence, teens are working hard at mastering a number of developmental tasks. Successfully meeting these challenges can positively affect their development. Some of these tasks are:

- establishing a unique sense of identity
- reconfiguring relationships with family as well as with school personnel
- developing sound judgment and problem solving
- developing the ability to take another's perspective
- developing the ability to use thought to "modulate," affect and control behavior
- developing the ability to plan and orient themselves to the future.

While attempting to master these developmental tasks, many of the demands of adolescence conflict with the work the adolescent must do. For example, a teen has the capacity for sexual intercourse, but may not be prepared emotionally or psychologically. Fortunately or not, risk-taking is one of the major tools that adolescents use to define their identity. Like it or not, risk taking is part of the adolescent equation.

Adolescence is also a time of growth in which young people try on new attitudes and behaviors to figure out what kind of adults they are supposed to become. The teen must consider his/her actions in terms of pleasing themselves, establishing and maintaining peer relationships, as well as attaining the recognition and support of important adults. This is a very difficult task that requires recognition of their own values, goals and desires, while-maintaining a connection to the values of family and community.

Many of the problems of adolescents have to do with an "imbalance." Adolescents experience life in an "either/or" situation, where both cannot exist. "It's either my friends or my family"..."I'm very successful at school or I never show up"... "I'm fine and dandy and life is OK or I must take medication and, therefore, something is really wrong with me." These imbalances also occur between:

- capacity and judgment
- consideration of the future and attraction of the present impulse
- possible actions and difficulty dealing with their consequences
- the needs of the adolescent and the expectations of his/her family.

These imbalances create a situation where the adolescent fluctuates from one side to another (mood swings), from paying attention to his/her own needs, the needs and desires of peers, while paying attention to family needs and demands.

Physical differences also develop during adolescence and have a new impact as the adolescent attempts to define himself or herself. There are more biological and physiological changes during early adolescence than at any other time since the first year of life. Problems often arise as the adolescent experiments with different solutions. These can be reinforced by peers, the media and can develop into a persona of their own. For example:

- need for affection... leads to... sexual promiscuity
- dieting... leads to... eating disorders
- drug experimentation... leads to... drug abuse and addiction
- depression... leads to... suicide

Adolescence can truly be a frightening time for teenagers. They may be feeling insecure, with their bodies out of control and exhibiting new risk-taking behaviors, while parents and other adults feel shut out and excluded from these important changes. And there is no denying that the teenage years are for some, a perilous phase; witness the alarming rates of teenage drug abuse, pregnancy and suicide. The challenge for parents and teachers is to teach adolescents risk-assessment with limits, talk about choices and consequences of their behavior, and steer them toward activities that will challenge, but not destroy them.

Adolescents, often influential, frustrated, frustrating, confused, ever changing and paradoxical, demand a new consideration and greater understanding especially in relation to

ADHD. These "transitional" beings, neither children nor adults are molded by and varyingly belittled and praised by adults, and in turn, both defend and downgrade themselves. Because of the way they think (egocentrically), adolescents are locked into the present; the time they live in is larger and more important than the future or the past. They see themselves as unique beings, constantly in the spotlight and they become increasingly self-focused, self-conscious and sometimes very moody, all normal parts of being an adolescent.

Major issues for many adolescents include impulsivity, distractability, disorganization, day-dreaming, and lack of initiative. (Flick, 2000). These are all exacerbated for adolescents with attentional disorders. Educators and parents need to be sensitive to this so as to not overlook the possibility of ADHD and dismiss the signs of an attentional difficulty as typical adolescent behavior. It is a matter of degree to which these issues interfere with daily functioning. In addition, the core symptons of ADHD may change with adolescents. Overt hyperactivity often diminishes or changes in quality from observable motor overactivity to a less observable internal feeling of restlessness. (Brown, 2000). Difficulty with focusing, sustaining attention and organization, however, does not diminish. (Weiss & Jain, 2001). It must also be kept in mind that adolescent girls are particularly likely to be underidentified as having attentional difficulties because they are less likely to be disruptive, and their struggles are likely to be seen as manifestations of general moodiness or as related to the onset of menarche. (Weiss & Jain, 2001).

Educators and parents also need to look for signs of immature behavior in adolescents: a preference for socializing with younger students, excessive silliness or excessive daydreaming, appearing to be in a fog, disruptive behavior, difficulty comprehending material that most students easily get, interpretations that are typical for younger students. It is difficult in some instances to identify these behaviors as signs of an attentional disorder.

Because of all the above, many adolescents go undiagnosed. It is also the case, however, that many adolescents have been helped by educators and parents. They are willing to consider their behavior as more than just normal adolescent concerns, while taking steps to confer with other professionals about these teenagers. They then work with these young people to manage their attentional difficulties.

Just as adolescence is a time of change, the symptoms and characteristics of ADHD change as well. When undiagnosed, misdiagnosed or confused with normal adolescent behaviors, ADHD can wreak havoc on an individual's self-esteem. As a result, many teens are left dealing with feelings of inadequacy, believing they are stupid, lazy or both. A number of teens even turn to alcohol or drugs in an attempt to "fix" the problem. This is when parents and other concerned adults really must be quite vigilant and determine what is "normal" adolescent behavior and what is not.

Most people, adolescents included, do not outgrow ADHD, but they can learn to adapt and live with it; many leading very successful lives.

12 CHARACTERISTICS OF TEENAGERS WITH ADD

Teenagers, with attentional disorders...

1. are frequently not focused.
2. have difficulty obeying rules and complying with requests.
3. have difficulty making transitions.
4. display a lack of the awareness of time and its importance.
5. have a performance level that decreases with the repetition and extended length of an activity.
6. often have difficulty identifying what's important academically and paying attention to it.
7. often have difficulty with organizational skills, forgetfulness, and poor memory skills.
8. don't tend to generalize or see the similarities in differing situations.
9. frequently display inconsistent behaviors.
10. often are self-centered and often have problems with everyday events.
11. often have deficits and display slow and/or superficial processing in one or all of the following areas: listening, speaking, reading and writing.
12. react differently to behavior management strategies, depending on their stage of development.

1.

Teenagers with attentional disorders are frequently not focused.

To help teenagers focus in on what is important:

School

- Have the student in classes that provide a calm and structured environment. Make the student an active participant by asking them to relate their goals for each class.
- Make eye contact with the student.
- Seat the student away from distractions.
- Give an established cue before making an important announcement.
- Establish a signal to indicate that they are about to be called on.
- Use high interest teaching methods and aids.
- Use a multisensory approach.
- Divide work into smaller segments and schedule short work periods.
- Keep instructions clear and concise.
- Provide activities that allow movement and involve the student.
- Do more hands-on activities.

Home

- Be sure that your teenager is in classes that are calm and structured.
- Provide supervision.
- Check homework one assignment at a time to be sure your teenager is on task.
- To catch a problem before it goes too far, get weekly reports.
- Reward good weekly reports with an activity on the weekend of your teenager's choosing.
- Encourage interaction between your teenager and family.
- Give your teenager appropriate tasks to do.
- Provide a quiet area as free from distractions as possible where your teenager can do homework, read, etc.
- Develop a set of silent cues that can be used when in a group so that your teenager will not be embarrassed when called on to refocus.
- Get your teenager involved in an activity or sport.

School

- Use role playing to act out events or key concepts.
- Use computers.

Home

- Plan family outings with your teenager.
- Avoid situations that might lead to your teenager acting impulsively and thus being distracted.
- Anticipate when difficulties might arise because of your teenager's impulsiveness and be ready to intervene
- Avoid preaching, but rather be a role model by staying focused on whatever activity you are working on.

2.

Teenagers with attentional disorders have difficulty obeying rules and complying with requests.

To help teenagers obey rules and be more compliant

School

- Explain rules clearly.
- Make rules few in number and simple.
- Post rules in writing.
- Go over rules verbally and discuss consequences.
- Have the student copy rules into a notebook if written output skills are not problematic, or provide a copy for student.
- Be consistent and follow through.
- When making a request, be sure that the student heard and understood the instructions by having student restate them out loud.
- If necessary, restate request and be sure the student follows through.

Home

- Develop rules together.
- Post rules in writing.
- Be sure consequences are understood.
- Be consistent and follow through.
- When making a request, be sure your teenager heard what you asked /have your teenager repeat the request.
- To be sure your teenager has not already forgotten your request, restate the request and then be sure your teenager follows through with what has been asked.

3.

Teenagers with attentional disorders have difficulty with transitions.

To help teenagers make transitions:

School

- Let the student know exactly what is going to be happening next.
- Let the student know how much time he has until the next event.
- Give the student some time in between two activities.
- When the new activity begins, monitor the student to be sure a successful transition has been made.
- Prompt the student, if necessary, by walking over and asking if he has any questions about the new assignment.
- Give notice when class is about to end and ask the student where he is going next.
- Encourage the student to ask questions about anything different (assemblies, sports sign-ups) going on that he is not sure about.

Home

- Let your teenager know what he/she is going to be doing and when.
- If it is something your teenager has not done before or some place he/she has not been before, ask if they have any questions.
- Try to make your teenager as comfortable as possible.
- If possible, give your teenager a choice as to what he/she would like to do next.
- When a transition has gone smoothly, be sure to praise your teenager.
- As your teenager gets older, give him/her the chance to make some “non-essential” transitions on his/her own with you monitoring, after the fact, to see if the transition was successfully completed.

4.

Teenagers with attentional disorders display a lack of the awareness of time and its importance.

To help teenagers deal with time appropriately:

School

- Be sure the student can tell time.
- Discuss importance of things being done on time.
- Decide together how much time will be allowed for each task.
- Use a timer to let them know how much time they have left.
- Watch to be sure they are using the time appropriately.
- Stop activity and collect work at designated time to reinforce idea that time line must be met.
- Homework should be expected on time unless arrangements for more time have been made ahead of time.
- The student should know ahead of time the consequences of not meeting deadlines (getting to class on time, etc.) and face those consequences.

Home

- Set a wristwatch alarm for key times.
- Provide your teenager with his/her own alarm clock and beeper.
- Give your teenager advance notice and a time frame for doing something.
- Teach time management and planning.
- Using a weekly schedule, mark the hours to help make abstract concept of time management more concrete and visual.
- Show your teenager how to schedule backward to finish a project on time.
- Together make a list of the activities for the week and post them on a weekly schedule so your teenager can visualize the time needed to do all the activities.
- Have a time set aside for homework.
- Let your teenager know the amount of time spent on homework will vary depending on how much work he/she has and how well it is completed the first time around.

School

- Check over all work collected and return to be redone that which had obviously been done quickly and that had not been checked over for errors, etc.
- Praise the work that the student took the time to do well and correctly.

Home

- Check each assignment for accuracy and neatness.
- Have your teenager redo what is not acceptable.
- Praise your teenager when an assignment has been done well the first time.

5.

Teenagers with attentional disorders have a performance level that decreases with the repetition and extended length of an activity.

To help teenagers improve their performance level:

School

- Plan to do work that requires the most concentration first.
- Use high interest material, interactive learning, multisensory approach.
- Keep instructions brief and simple.
- When repeating an instruction, rephrase it in different terms.
- Divide work into smaller segments.
- Provide a variety of activities including one that will allow movement.
- Give frequent positive feedback.
- Teach them to recognize when they are going off task.
- Use cues to remind them when it is very important to be on task.
- Give a short quiz on the activity just completed to stress its importance.

Home

- Have study area away from distractions.
- Supervise homework.
- Monitor getting started.
- When one assignment is completed and checked, allow a short break.
- Use a cue to signal when it is time to get started again.
- Watch when your teenager is doing an assignment and provide a reminder when he/she is off task.
- If your teenager is not able to get back on task, review what he/she has done so far or go over the directions.
- Use positive feedback.
- Break down chores and other activities into short segments and do most important ones at the beginning of the day.

6.

Teenagers with attentional disorders often have difficulty identifying what is important academically and paying attention to it.

To help teenagers identify what is important and pay attention to it:

School

- Provide an outline of the material to be covered.
- Give the student a copy of written material and have them highlight key words and ideas.
- Eventually have them develop their own outlines.
- Teach them how to identify important information, for example: bold type, italicized words.
- Have two students work together going over new material and deciding together what is important.
- Test only the material that has been decided to be the most important so that the student will realize that he only needs to focus on what has been labeled important rather than trying to learn everything.

Home

- When helping with homework, stress only that which has been identified as important by the school.
- When a situation arises when your teenager must make a decision, have a discussion about what is and is not important and stress that he/she should focus in on only what is important.
- When your teenager strays from that decision, remind him/her of what has been decided.
- Be ready at any time to give your teenager guidance in selecting what is important and sticking with that decision.

7.

Teenagers with attentional disorders often have difficulty with forgetfulness, organizational skills, and poor memory skills.

To help teenagers who are disorganized, forgetful, and have poor memory skills:

School

- Place the student in structured classrooms.

Forgetful:

- Require assignment book.
- If necessary, sign the assignment book each day and ask parent to do the same.
- Have the student keep work in a notebook or folder (color-coded).
- Always have homework turned in at a specific time and in a specific place.

Disorganized:

- Provide the student with a list of items needed for a project.
- Act as a model being prepared and organized yourself.
- Use verbal cues, such as "first", "next", to keep the student on task.
- Encourage the student to question any directions or instructions not understood.
- Assign a peer tutor to work with the student on a new activity.
- Allot time at the beginning and end of each class for the student to organize himself.
- Also allow time between activities for the student to get reorganized and to take a short break.

Home

- Seek a structured classroom for your teenager.

Forgetful:

- Remind your teenager to put needed materials at specific activity centers.
- Make a written list of chores to do.
- Use "post-it" notes.
- Help get started and show how to do the activity.
- Ask your teenager for help with something you are doing so you can model organizational skills.
- Put name on possessions.

Disorganized:

- List steps in how to do a certain chore or activity.
- Establish a basic routine that is followed each day.
- Work closely with teachers so that expectations are the same.
- Set aside an area in the home where homework is to be done.
- Go over assignments listed in the assignment book discussing, perhaps, what should be done first, etc.

School

Disorganized: (Continued)

- With each assignment and activity, provide structure by giving, specific directions, format, timetable, etc.
- Review often where the student is in the activity being worked on.

Memory:

- Teach strategies for memorization.
- Encourage the use of flash cards or tapes.
- Make a copy of material being studied and have student highlight what needs to be memorized.
- Allow student to use spell check or dictionary.
- Give two grades on written material: one for content and one for spelling.
- Allow use of calculator or multiplication charts.
- Teach math shortcuts.
- Reduce work assignment if work is completed accurately.
- Make use of videotapes or computer software programs that will give immediate feedback.

Home

Disorganized: (Continued)

- Frequently check on progress and sign book only after all work is successfully completed.
- Get a tutor or academic coach, if necessary.
- Have your teenager use a backpack.
- Work with your teenager reorganizing backpack daily.
- Each night, have your teenager get backpack ready for the next day and placed in the same spot.
- Anticipate problems and be ready to make adjustments without too much disruption to the routine.

Memory:

- Using flash cards or tapes, work with your teenager to help memorize material.
- Go over highlighted material with your teenager.
- Use word association and mnemonics when helping your teenager learn material.
- Invest in computer software programs that will reinforce skills your teenager is learning.

8.

Teenagers with attentional disorders do not tend to generalize or see the similarities in differing situations.

To help teenagers generalize:

School

- Make them aware that, in your classroom, you follow the same basic rules and procedures as the rest of the school.
- Point out, whenever possible, how items or events are similar, for example: explain how textbooks are organized or how the rules of a certain game are always the same.

Home

- Give your teenager examples of generalities that he/she can easily relate to, for example: tell your teenager that the basic laws he/she must follow when driving a car are the same in every city and state.
- Be ready to point out how a situation, rule or procedure is the same when a situation is the same.

9.

Teenagers with attentional disorders frequently display inconsistent behaviors.

To help teenagers with inconsistent behaviors:

School

- Watch for inconsistent behavior.
- Sit alone with student and discuss inconsistencies.
- Work out a contract that will help develop more consistent behavior in the classroom.
- Be a good role model by being as consistent as possible in the running of your classroom and especially in dealing directly with your students.
- Talk with the parents to let them know what you are expecting.

Home

- Encourage consistent behavior by pointing out when behavior is inconsistent and by letting your teenager know which behavior is more appropriate.
- When behavior has been consistent for a certain period of time, be sure to praise your teenager.
- Work with the school so that everyone will have the same expectations.
- Be sure to be consistent yourself

10.

Teenagers with attentional disorders often have problems with routines in everyday events.

To help teenagers deal with routines:

School

Home

A. Sleep Disturbances:

- Set a reasonable bedtime.
- Provide cues to get ready for bed.
- Set up a bedtime routine.
- Avoid starting projects after a set time.
- Compromise only for very special events.
- Encourage exercise but not too late in the evening.
- Do not allow television or computer in bedroom.

B. Difficulty with Morning Routine:

- Allow enough time for morning routine.
- Buy an alarm clock.
- Use logical consequences if routine not adhered to (e.g., walk to school if ride is missed; leave on time and finish getting ready in the car; give 10-minute warning and then take away privilege).
- Get prepared the night before.
- Discuss with the doctor the idea of giving medication as soon as the teenager wakes up.

11.

Teenagers with attentional disorders often have language deficits and display slow and/or superficial processing in one or all of the following areas: listening, speaking, reading and writing.

To help teenagers deal with attentional disorders improve their language deficits:

School

A. Listening

- Keep instructions clear and concise.
- State directions clearly and sequentially.
- Use prompts to get attention.
- Ask student to repeat instructions.
- Write instructions on index cards or post-it notes.
- Use an adaptation such as a verbal test instead of a written test.
- Use a computer instructional program.
- Provide a copy of notes from another student or the teacher.
- Provide guided lecture notes for the student.
- Tape record lecture.
- Provide cues for important points.

B. Speaking:

- Be supportive
- Be positive and praise correct answers.
- Give notice before calling on student.
- Allow more time to respond.
- Avoid criticism.
- Teach outlining and sequencing to help with organization of thoughts.
- Create less threatening situations in which to speak publicly.

Home

A. Listening:

- Work closely with the teachers so that you can reinforce what is being done to help your teenager in all these areas.
- Keep directions clear and concise.
- Write reminders on post-it notes.
- Ask the teacher to tape lessons so that you will know exactly what material is being covered in class or get a copy of the teacher's notes.
- Have your teenager put important information on notecards so that he/she can visually see what he/she has heard.

B. Speaking:

- Be patient while the teenager is speaking.
- Allow your teenager time to formulate an answer before he/she speaks.
- Help your teenager by asking what happened first and then what happened following that.

C. Writing:

- Have a computer your teenager can use for homework.
- Get a copy of writing guidelines so you can work with your teenager on these skills.
- Check note cards to make sure they are in order before your teenager writes the report.

School

C. Writing:

- Use computer or laptop.
- Use computer instruction.
- Develop strategies for theme writing.
- Model skill being taught.
- Use modifications and/or alternatives to writing.
- Use note cards for main concepts.
- Modify the test – untimed or provide a reader.

D. Reading:

- Use *Talking Books.*
- Seat student away from distractions
- Keep written instructions brief and simple.
- Modify assignments.
- Provide additional time for doing work and tests.
- Allow peer tutoring.
- Teach to strengths as related to student's learning style.

Home

- Proofread material pointing out areas that need revision.

D. Reading:

- Have your teenager slide a bookmark down the page as he/she reads.
- Use published book summaries or videos as supplementary aids.
- Check into the availability of *Talking Books.*
- Get audiotapes of books from library.
- Set aside a quiet area where your teenager can read.
- Set a good example by spending some time reading while your teenager is also reading.

Material gathered from:

Teenagers with ADD – A Parents' Guide
Chris A. Zeigler Dendy, M.S.
Bethesda, MD: Woodbine House, 1995

In developing the section on Secondary Interventions and Strategies the above cited book was used as a reference. It provides an in depth look at teenagers with ADD and is an excellent guide for both parents and professionals.

12.

Teenagers with attentional disorders react differently to behavior management strategies, depending on their stage of development.

To help students increase positive behavior:

School

- Select a reinforcer that is readily available, can be delivered immediately following the desired behavior, and can be used frequently.
- Begin with tangible reinforcers and move toward social reinforcers.
- Have available a menu of reinforcers.
- Reinforce as quickly as possible after the desired behavior occurs.
- Describe the behavior that is being reinforced and explain the reinforcement plan.
- Gradually decrease the number of reinforcers given.
- When student engages in inappropriate behavior, first remind student what he/she is supposed to be doing and immediately reinforce the change.
- If student does not change the behavior, consider using an effective form of timeout.

Home

- Select a specific behavior to reinforce.
- Select a reinforcer that's readily available, can be delivered immediately following the desired behavior, and can be used frequently.
- Begin with tangible reinforcers and move toward social reinforcers.
- Have available a menu of reinforcers.
- Reinforce as quickly as possible after the desired behavior occurs.
- Describe the behavior that is being reinforced and explain the reinforcement plan.
- Gradually decrease the number of reinforcers given.
- Give frequent non-contingent positive reinforcement.
- When your teenager engages in inappropriate behavior, provide a reminder of what he/she is supposed to be doing and immediately reinforce change.

School

- If student does not change behavior, consider using response cost.
- Eliminate stimuli that might be eliciting the inappropriate behavior.
- Tell student why timeout and response cost are being used and explain the plan.

Home

- If your teenager does not change behavior, consider using an effective form of timeout.
- If your teenager does not change behavior, consider using response cost.
- Tell student why timeout and response cost are being used and explain the plan.

Guidelines for Communication to Support Home and School Team Building

(NOTE: see Chapter 3, Referral and Identification Procedures for Special Education)

Introduction

The involvement of families is of primary importance to the success of any efforts made on behalf of students. When the linkages between school and families are strong, families feel valued and schools gain access to the important perspectives of families on the roles they can play and on their children's strengths and needs. It is far easier to build and maintain family/ school involvement when it is begun early.

Contacting parents when concerns arise

The following guidelines are suggestions for the first contact with families when someone has indicated a concern about the child's attention to task, completion of schoolwork or about the child's tendency to act impulsively. These first contacts set the tone for all future communication and team building efforts. To facilitate this process:

- Set up an ongoing communication process at the beginning of the year. When concerns do arise, contact will be natural and comfortable for both teachers and families.
- Initial contact regarding attentional issues can be either written or by phone depending on existing home/ school communication system.
- Do not leave a message on machines or with children. Calling parents at work can also be unduly alarming.
- Telephone calls should be brief. The goal of this contact is to inform parents in a low key manner of concerns and to set up a mutually convenient time for a conference to share information.
- Resist the temptation to give out too much information on the phone. This is not the time to offer conclusions, reasons, causes or solutions.
- DO NOT DISCUSS MEDICATION

Suggested format for the first parent teacher conference:

The purpose of the first parent / teacher conference is to discuss the specific concern regarding the child's attention to, completion or organization of schoolwork, or about his / her tendency to act impulsively. This is an opportunity to share information, explore home and school factors, and discuss helpful interventions and resources.

- Begin by making a positive statement to parents regarding the parents' interest and concern for the child

- Acknowledge the fact that phone calls or notes home can be disconcerting.
- Provide positive information about the student (e.g., he has a great sense of humor, she has been doing well on math facts this week.)
- Ask open ended exploratory questions for some basic information and to establish a rapport with the family (e.g., "How is Mary feeling about school?")
- Avoid using jargon. Be sure to explain and define any unknown terms.
- Engage in active listening.
- State specific school concerns and give concrete, measureable examples. Be sure to include academic information as well as behavioral information.
- Discuss the coordination of intervention strategies for home and school.
- Provide information regarding helpful resources or if indicated, discuss the more formal information gathering steps (see Chapter 3, Referral and Identification Procedures for Special Education).
- At the conclusion of the meeting, parents and teachers agree upon a follow-up plan, as simple as a phone call or note or as formal as a next meeting which can be initiated by school personnel or by family.

Attentional difficulties and medical interventions: questions on roles and responsibilities of school personnel

Should a teacher suggest to a family that a student may have an attentional disorder?

Teachers are often the first people to identify concerns with high activity levels, distractibility or concentration in students, and therefore, often are the first to talk with families about these concerns. It is appropriate for a teacher to describe particular behaviors and ask a family if they have discovered successful ways to respond to or avert them. It is also appropriate to discuss other responses that might be successful in the classroom and/or at home. Teachers may also talk about how the student's behaviors affect his/her work and interactions. The goal, at this point, is to modify the student's *environment* – physical, interpersonal and instructional – so as to reduce the incidence and intensity of inappropriate behaviors.

However, *it is NOT the teacher's role or responsibility to presuppose the presence of an attentional disorder or to recommend the use of medication.* In addition, it is *NOT* prudent for a teacher to recommend the involvement of a physician at any point in the referral, diagnostic or remediation process. It *would* be appropriate for a teacher to confer with the person(s) designated within the school to address concerns about attentional difficulties.

Whose role is it to recommend to families that a child with attentional concerns have a trial of medication?

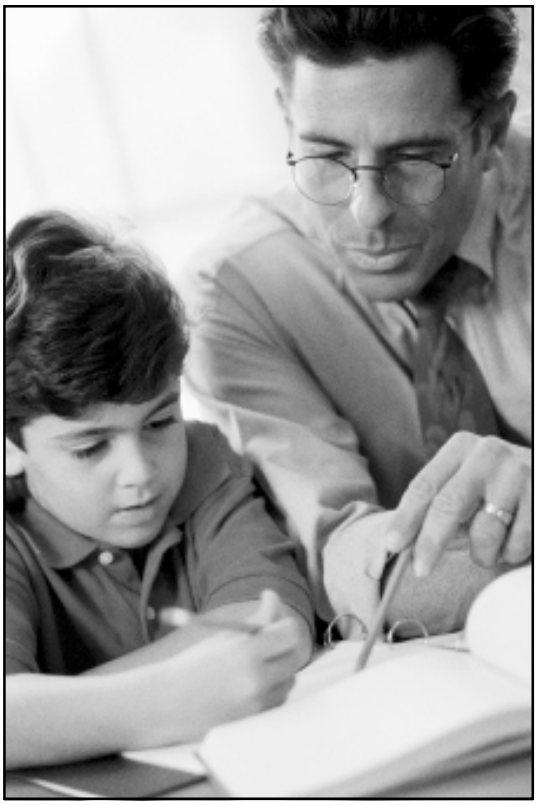
While medication is often an integral part of a multi-modal intervention plan for a student with an attentional disorder, the *only* person whose role, responsibility and right it is to recommend a trial of medication is a physician, physician assistant, or nurse practitioner. Such recommendation should be made only after an extensive thorough, multi-modal evaluation indicates that it would be appropriate.

What is the appropriate role of the person designed to address concerns about attentional difficulties?

In talking with a family, a designated person may discuss a student's behaviors in an objective manner, as described in the first paragraph. If thorough exploration of the student's environment does not indicate another reason (s) for his/her behavior, the designated person may suggest that a medical evaluation might be appropriate to investigate other contributing factors. Specific medical conditions should *NOT* be mentioned by unqualified personnel.

If a student's physician is considering or has prescribed medication for the student, what is the appropriate role of school personnel?

It is appropriate for school personnel to provide observations of a student's behaviors for use by a physician in managing medication levels. It is *NOT*, however, appropriate for school personnel to make judgments about medication levels or efficacy or to suggest other medications to parents. It is *NOT* appropriate for school personnel to ask a student about his/her medication, or to make anyone else aware that a student takes a medication. School personnel are qualified *only* to describe a student's behaviors in specific environments at particular times.



CHAPTER 3

Referral and Identification Procedures for Special Education

Introduction and Organization

This section is organized according to the procedures that are to be followed when an individual is seeking assistance. The following questions, which are answered in this chapter, are often asked as a person goes through the steps necessary to assess a student's needs:

Questions:

I. Is someone concerned about the student's attention to, completion of, or organization of schoolwork, or is someone concerned about his/her tendency to act impulsively?

II. Does someone* think that the Teacher Support Team (TST) should explore the student's need for additional modifications and/or support? (**the student's family, teacher, other professional dealing with the student, or the evaluation team*)

III. Does someone* think that there is a need to consider a formal evaluation under either special education or Section 504 requirements/guidelines? (**the student's*

family, teacher, other professional dealing with the student, or the TST)

IV. Has the appropriate team of people decided that either special education or Section 504 evaluation is indicated?

V. Has it been determined by a formal evaluation team that additional and/or alternative services are needed for the student?

VI. Flow Chart

Procedural Steps

I. Is someone concerned about the student's attention to, completion of, or organization of schoolwork, or is someone concerned about his/her tendency to act impulsively?

A. Communication and information gathering between family and school should involve:

1. Discussion of the concern between school and family representatives

    a. exploration of home and school factors

    b. sharing of information, helpful interventions and resources

    c. if indicated, discussion of next steps.

2. Use of classroom-centered tools to assist in observation of student's levels of attention, work completion, organization, impulsivity, etc. [for example, the Connors Teacher Questionnaire (CTRS 28) and the Children's Attention Profile].

3. Discussion between school and family representatives of findings and implications of the formal classroom observation.

4. If indicated, use of family-focused tools to gather more information [for example, Connors Parent Questionnaire (CRPS 48) and structured family interview, to be administered by qualified psychologist or social worker].

B. Collaborative analysis of information and selection of appropriate steps to take (meeting to include family and school representatives, including teacher; the family should be made aware that they may be accompanied at any time by a friend, support person, etc.) should involve:

1. sharing and explanation of assessment findings

2. discussion of implications, including whether the concern is recent and/or situational or if it is moderate to serious

3. explanation of procedural choices, including a direct referral to request a comprehensive evaluation, in order to assure appropriate selection of an informed consent for next step(s) such

as a Section 504 referral or special education evaluation

a. identification and implementation of interventions

- home and school based intervention strategies for appropriate classroom and home modifications(refer to Chapter 2)
- document planned interventions and prepare to record effectiveness using consistent, measurable means
- plan to reconvene participants to review progress
- it is incumbent upon the school principal or designee to ensure transmission of modifications to all staff members dealing with the student, to assure continuity of modifications in following years, and to assist with home/school communication

b. Referral to the Teacher Support Team

- compile information for referral
- forward to person responsible

c. referral for further evaluation

- if further evaluation is warranted, compile referral information to be considered according to evaluation requirements/guidelines of either special education or Section 504
- forward to person responsible

II. Does someone* think that the Teacher Support Team should explore the student's need for additional modifications and/or support? (**the student's family, teacher, other professional dealing with the student, or the evaluation team*)

A. Membership

NOTE: The Teacher Support Team (TST) consists of the following individuals:

1. Family (and their invited support person, if applicable)
2. A teacher who is knowledgeable about the student (may include a former teacher)
3. Person knowledgeable about the identification of attention disorders and appropriate intervention techniques (staff member or outside resource)
4. Person(s) who collected data from family and teachers
5. Administrator or designee with decision-making authority as chair and convener of meeting(s)

B. Activities

1. Sharing of information already gathered

2. Problem definition and prioritization

3. Consensus planning for action at school and home

4. Documentation of plan, including specific behavioral interventions

5. Setting of follow-up date and responsibilities

6. Follow-up meeting to assess outcomes of interventions

7. Return to B.1

(NOTE: if the Team of qualified professionals and the parent (evaluation team) has forwarded the case of a student with an outside diagnosis of attention disorder, this may be the first time the Teacher Support Team(TST) has been involved; it must proceed to obtain information as described in Question I, if it is not already available).

C. Timelines – Suggested

1. Within 10 school days of the initial meeting, theTeacher Support Team (TST) must decide whether or not to refer the student for further evaluation.

2. The TST should continue its activities as long as they are bringing about positive change.

3. If for a particular student the TST no longer feels the need for short-term follow-up meetings, it should nevertheless set a date to reconvene some time in the future to check on the student's situation.

III.Does someone* think that there is a need to consider a formal evaluation under either special education or Section 504 requirements/ guidelines? (**the student's family, teacher, other professional dealing with the student, or the Teacher Support Team*)

NOTE: If the student is eventually referred to the Section 504 team or the special education evaluation team (team of qualified professionals and the parent and other professionals, as appropriate) a history of modifications attempted for this student and their results must be documented.

NOTE: If the family presents an outside diagnosis of attention disorder to the school, it must be treated as a referral to be reviewed by a special education evaluation team. The evaluation team will decide if a special education evaluation is needed. If a special education evaluation is not required, then the team must either

Assign the matter to their TST or refer the matter to the Section 504 team.

A. Process – Suggested
If there is a condition that is suspected to be a disability as described in Section 504

1. A referral should be made to the

designated Section 504 individual who must

a. establish a team procedure for review of the referral
NOTE: the regulations specify that a procedure which would comply with the process requirements for referral and evaluation under I.D.E.A. will also satisfy the requirements for decision-making under Section 504.

b. convene a team of persons knowledgeable about the student and the student's disability.

2. The team must consider the referral and make recommendations as to whether or not an evaluation is needed. If enough information exists, the team makes an eligibility determination. If eligible, the team will then proceed to develop a Section 504 accommodation plan.

B. If there is a condition that is suspected to be a disability as described in I.D.E.A.

1. A referral should be made to the special education director, school principal, or designated school employee and the Local Educational Agency (LEA) shall ensure that:

a. Within ten (10) school days of the receipt of a referral for special education services a team of qualified professionals and the parent that includes the individuals described in RI Regulation 300.531 and other qualified professionals, as appropriate, known as the **Evaluation Team**, meet to determine if a special education evaluation is needed

b. The initial evaluation (or re-evaluation) shall commence no later than ten (10) school days after the receipt of parental consent to conduct such an evaluation. If the parent does not notify the LEA within five (5) school days of their consent to evaluate, the team must document its efforts to obtain consent. If the LEA has not obtained parental consent to evaluate within fifteen (15) school days of the request to evaluate, the Team must reconvene to consider what action the LEA will take including (as appropriate) the requirements described in RI Regulation 300.505 (b) and (c), and RI Regulation 300.345 (d)

c. A full individual initial evaluation is conducted before the initial provision of special education and related services

Within forty-five (45) school days of receipt of parental consent to an initial evaluation:

- the child is evaluated; and

- a written report of the evaluation team is made available to

the LEA and the parent(s); and a team of qualified professionals and the parent(s) of the child meet as an eligibility team to determine whether the child is a child with a disability and in need of special education and related services.

2. If determined eligible under this part, an IEP meeting is conducted and an IEP is developed and special education and related services are made available to the child in accordance with an IEP within fifteen (15) school days of the eligibility determination and not more than sixty (60) school days of the receipt of parental consent to conduct the initial evaluation.

3. If it is determined that an initial evaluation is not needed, the evaluation team shall consider referring the student's case to either the LEA's teacher support team or the LEA's Section 504 team (Section 504 of the Rehabilitation Act of 1973). The parent(s) must be notified, along with a copy of their procedural safeguards, of the decision of the team not to evaluate within ten (10) school days.

IV. Has the appropriate team of people decided that either special education or Section 504 evaluation is indicated?

A. Evaluation under Section 504

1. Involve the family – in discussion of the concern and in planning for evaluations.

2. A team of knowledgeable and qualified people

   a. must determine which evaluations, informal and/or formal, should be carried out for the student

   b. if necessary, they may ask for appropriate evaluations as needed (procedural safeguards must be observed)

   c. may determine on the basis of evaluations that the student is protected under Section 504 because of attentional difficulties, whether or not there is a diagnosis of attentional disorder.

3. If after evaluations, the team determines that the student does not require services under Section 504

   a. the student and parents must be informed of

      - the steps they may take if they disagree with the decision (procedural safeguards)
      - their right to request an evaluation under I.D.E.A.
      - the referral to the Teacher Support Team

   b. the team must refer the student back to the Teacher Support Team

with an explanation, preferably in person by a member of the team.

4. If the team determines that the student does require services under Section 504, proceed to Question V.

B. Evaluation under special education

1. Proceed with evaluation – proceed as usual, but in determining which evaluations are needed, refer to Chapter Four, Diagnostic Evaluations, to help decide what evaluations already completed may be sufficient and what evaluations need to be done or added to.

2. Decision on disability

a. determine if the student has a disability covered under I.D.E.A. - has one of the following disability conditions: mental retardation, hearing impairment, including deafness, speech language impairment, visual impairment, including blindness, emotional disturbance, orthopedic impairment, autism including autism spectrum disorder, traumatic brain injury, other health impairment including attention deficit hyperactivity disorder, specific learning disability, deaf-blindness, multiple disabilities, developmental delay, and

b. analysis of results of the differential diagnosis should enable the team to determine whether the student has a disability according to the following criteria; it should be noted that attentional disorders may be associated with other areas of disability as well

CRITERIA:

(1) Learning Disability

(i) **General**. The term means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia.

(ii) **Disorders not included**. The term does not include learning problems that are primarily the result of visual, hearing, or motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

(2) Emotional Disturbance— a condition exhibiting one (1) or more of the following characteristics over a long period of time and to a marked degree, that adversely affects a child's educational performance:

(a) An inability to learn that cannot

be explained by intellectual, sensory, or health factors.

(b) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

(c) Inappropriate types of behavior or feelings under normal circumstances.

(d) A general pervasive mood of unhappiness or depression.

(e) A tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) The term includes children who are schizophrenic. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

(3) Other health impairment means having limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that –

(i) Is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, and sickle cell anemia; and

(ii) Adversely affects a child's educational performance. (RI Regulations 300.7)

c. if the evaluation team feels that it is necessary to do so, it may make a determination that a student has an attentional disorder, but only if:

- the team follows the guidelines for a sufficient, valid evaluation (seeChapter Four, Diagnostic Evaluations)
- at least one person serving on the team must have specific knowledge of how to identify the disability condition.
- these steps are clearly documented
- it is made clear to all parties and in writing that the team's decision is solely for the purposes of:
  - determining whether the student has a disability according to special education regulations
  - educational programming
- families are provided with:
  - information sufficient to ensure informed consent
  - a recommendation that they consult with a qualified physician for advice on the need for other than educational treatment

- an explanation of the components of a multimodel approach, including information on what a physician might recommend, and clarification that the school will only carry out educational and behavioral interventions (see ChapterTwo, Home and School Based Intervention)

(Note: School personnel must at all times avoid any suggestion, implicit or explicit, regarding medical treatment for an attentional disorder.)

3. If after evaluations, the evaluation team determines that the student does *not* require special education services

    a. the evaluation team should refer the student to the Teacher Support Team or the Section 504 Team with an explanation, preferably in person by a member of the evaluation team
    b. either the evaluation team or the Teacher Support Team must consider whether the student may have a disability that meets the criteria of Section 504 and make appropriate referral.

4. If the evaluation team determines that the student does require special education services, proceed to Question V.

V. Has it been determined by a formal evaluation team that additional and/or alternative services are needed for the student?

A. Planning

1. Include family, teacher(s) and other professional(s) who have been involved in the evaluation process

2. If the student is eligible for protection under Section 504, those responsible for the Section 504 plan are advised that they will meet appropriate Section 504 regulations if they adhere to the standard development and implementation requirements followed by special education IEP teams

3. If the student requires a special education IEP, follow all applicable regulations: be sure to document any behavioral interventions within the IEP.

4. Focus on consistency within the "environmental triangle" of home, school and community

    a. consider and plan for the ways each specific approach and technique will need to be applied and/or reinforced in the different settings

    b. plan for ongoing coordination of efforts and communication of outcomes between people in the different settings

c. clarify in writing what each person will do.

5. Refer to Chapter Two, Home and School Based Interventions and Appendix B for resources.

6. Specific services and placements are based on the individual student's needs as indicated by the evaluations and described in the student's plan.

7. Set early and continuing follow-up dates for regular checks on the effectiveness of the plan, using these guidelines:

   a. follow-up dates must be based on the contents of the individual student's plan

   b. timing of follow-up discussions will vary considerably between students

   c. individual items in the plan may need alteration or adjustment quite frequently.

B. Implementation

1. If the student has a special education IEP, follow standard implementation requirements; districts are advised to do the same for Section 504 plans.

2. Implementation of plans developed under either of these regulatory systems is mandatory.

3. Indicate in each individual student's plan the name of the person who will serve as Plan Coordinator

   a. the Plan Coordinator is a person who is thoroughly knowledgeable of the student, the assessment process and the plan, and preferably has been involved throughout the identification process

   b. responsibilities of the Plan Coordinator include:

      • personnel and family members involved

      • services being provided

      • community involvement

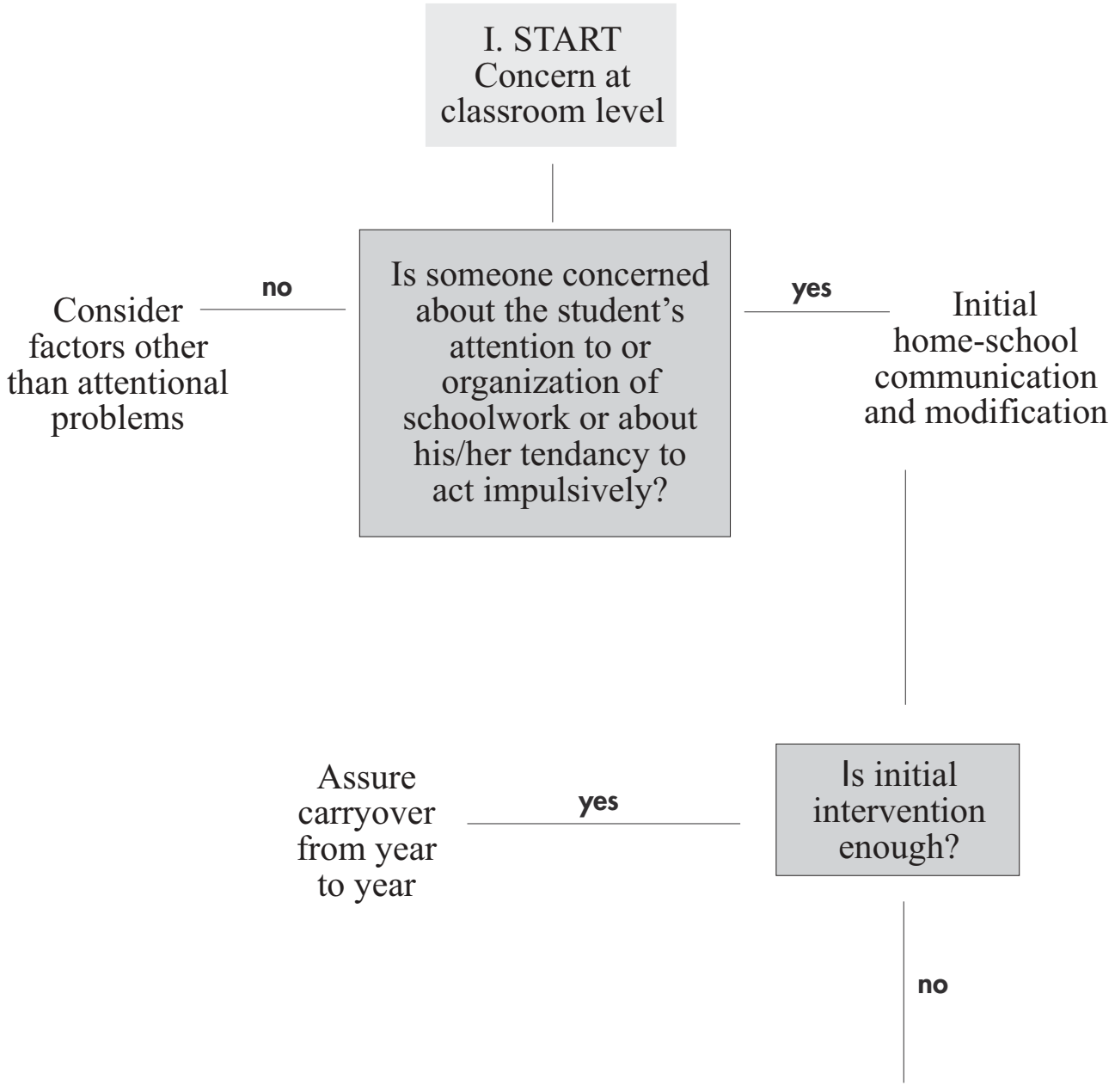
         - smooth student transition from year to year by assisting the uninterrupted carry-through of services described in the plan

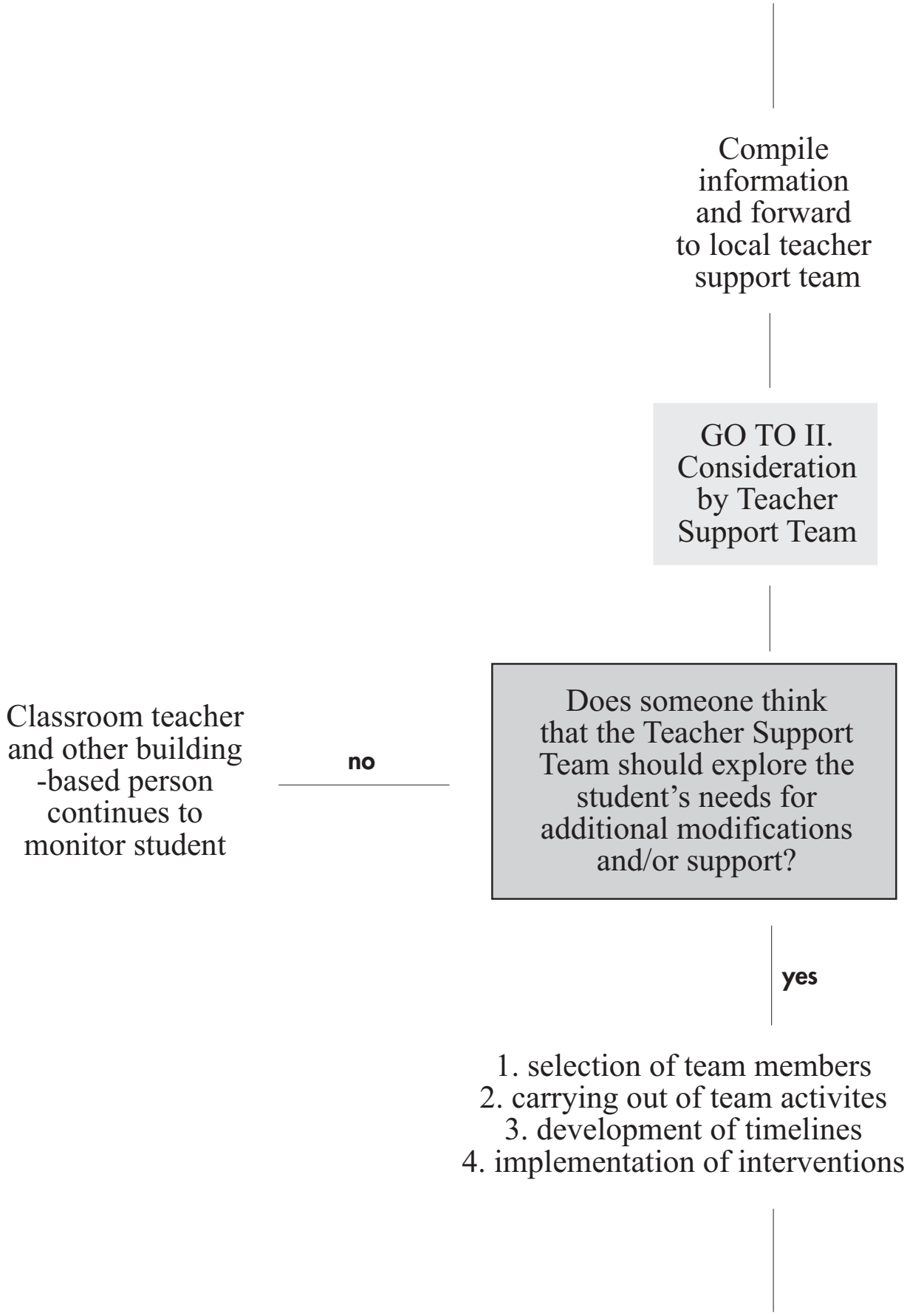
         - establish and maintain channels of communication between home and school and between all school personnel who work with the student.

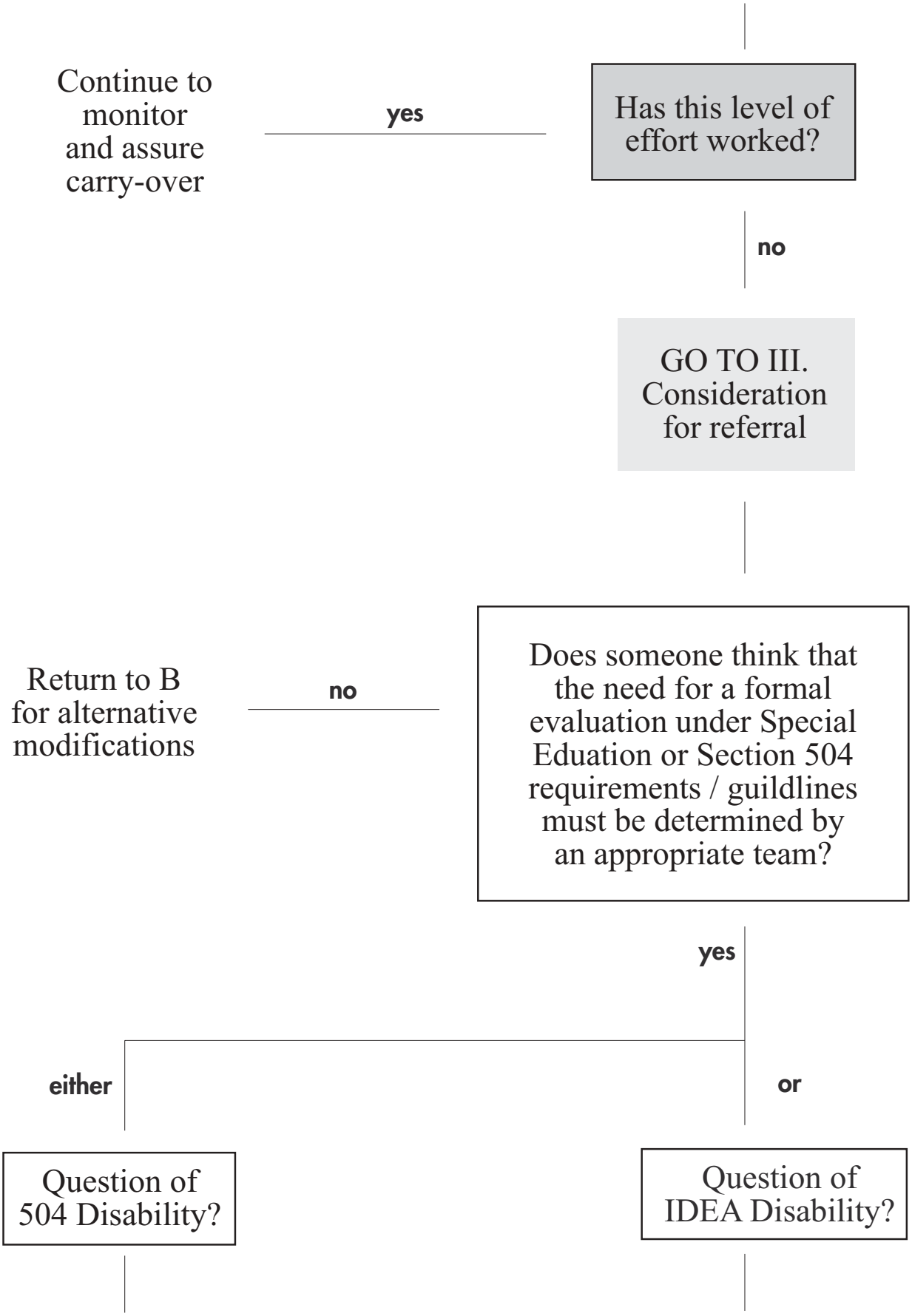
V. Flowchart of Procedural Steps in Decision-making Regarding Attentional Concerns

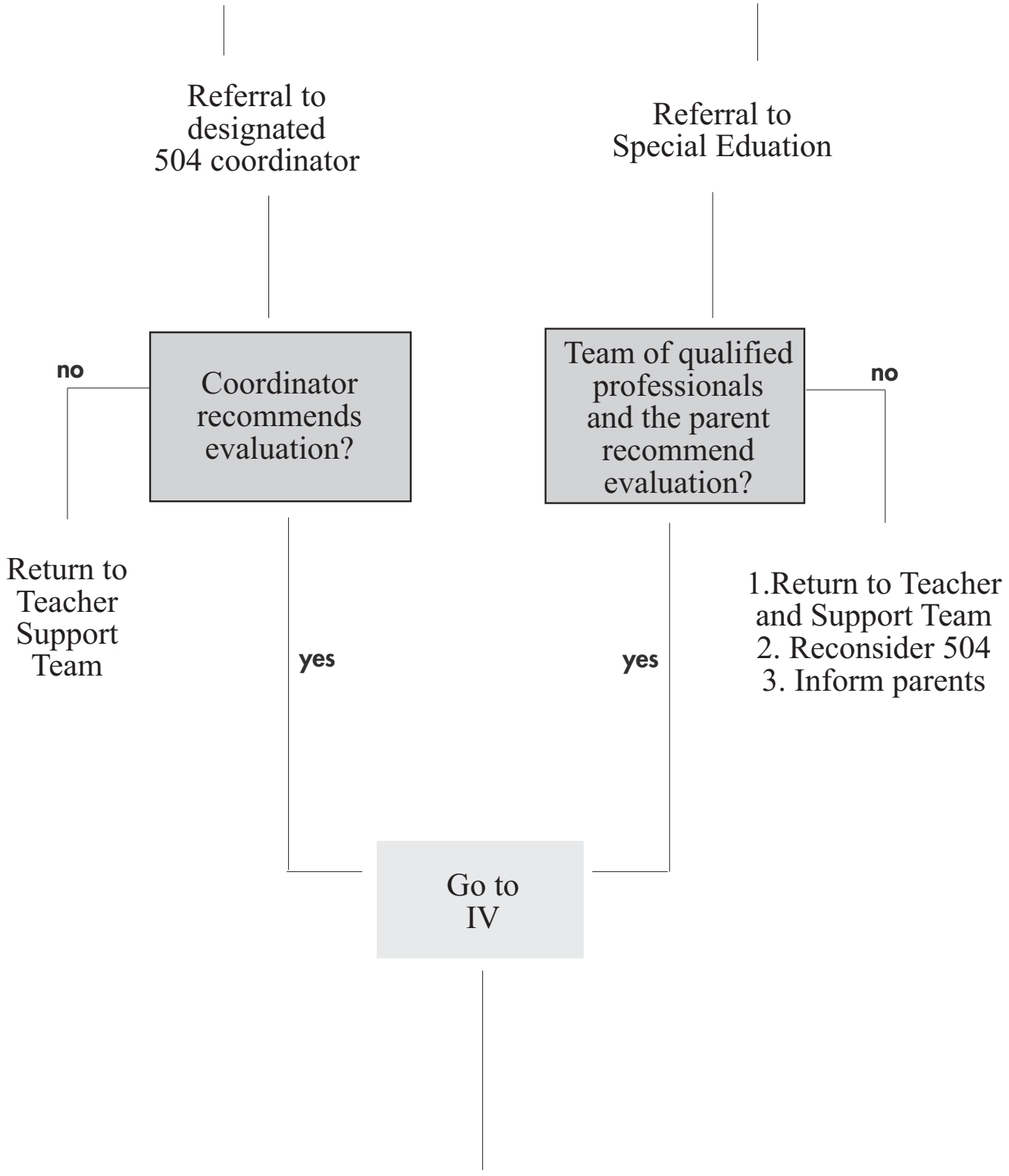
For detailed information refer to Referral & Identification

Procedures for Special Services

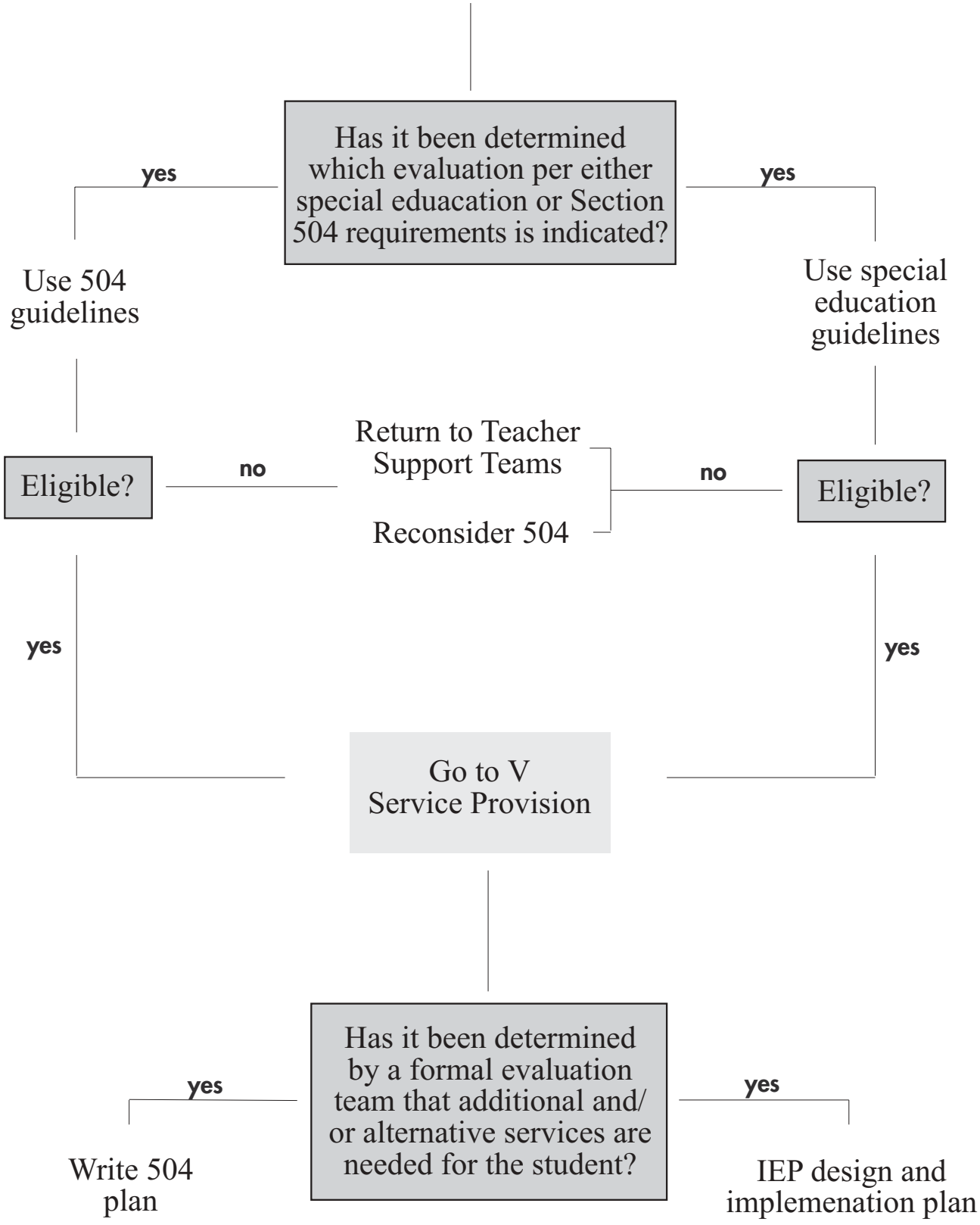



Compile information and forward to local teacher support team
GO TO II. Consideration by Teacher Support Team
Does someone think that the Teacher Support Team should explore the student's needs for additional modifications and/or support?
no
Classroom teacher and other building -based person continues to monitor student
yes
1. selection of team members
2. carrying out of team activites
3. development of timelines
4. implementation of interventions


Has this level of effort worked?
yes
Continue to monitor and assure carry-over
no
GO TO III. Consideration for referral
Does someone think that the need for a formal evaluation under Special Education or Section 504 requirements / guildlines must be determined by an appropriate team?
no
Return to B for alternative modifications
yes
either
or
Question of 504 Disability?
Question of IDEA Disability?



NOTE: If a family presents an outside diagnosis of attentional disorder to the school, it must be treated as a referral to be reviewed by the Special EducationTeam of Qualified Professionals and the parent.


Has it been determined which evaluation per either special eduacation or Section 504 requirements is indicated?
yes
yes
Use 504 guidelines
Use special education guidelines
Eligible?
no
Return to Teacher Support Teams
Reconsider 504
no
Eligible?
yes
yes
Go to V Service Provision
Has it been determined by a formal evaluation team that additional and/ or alternative services are needed for the student?
yes
yes
Write 504 plan
IEP design and implemenation plan

CHAPTER 4

INTRODUCTION
Diagnostic Evaluations

This section provides a framework for the comprehensive, multidisciplinary evaluation of attentional disorders. Many of the components of this process have been thoroughly researched and demonstrated to identify attentional concerns with a high degree of reliability. Some of the components do not have such a history, Much work is being done in this area, and the diagnostician should be alert as to the new instrumentation that is regularly forthcoming.

The diagnostic process can be conceived of as answering the following questions:

1. Does the student meet the criteria of the DSM IV?
2. Does the student receive elevated scores on attentional rating scales in comparison to students of the same age and sex?
3. Does the student demonstrate difficulty in two or more settings?
4. Does the student receive elevated scores in comparison to children of the same age and sex during formal, systematic, behavioral observation at school, home or in an office setting?
5. Does the student demonstrate difficulty on specific psychological and neuropsychological tests consistent with difficulties in vigilance and/or executive functions, or attentional skills?
6. Does the student meet the criteria for any other psychiatric and/

or learning disorder such as a nonverbal learning disorder?

To answer the questions, a five component evaluation plan is recommended with the possibility of a sixth and/or seventh component if the first five do not answer the referral question:

1. structured family interview including history.

2. standardized attentional and behavior rating scales done by parents and teachers (students also when appropriate), and any others working with the student

3. medical examination with verification that the student has no known sensory deficit or other medical condition that may mimic ADHD (i.e., petit mal seizure disorder)

4. systematic formal behavioral observation either in school or in another setting

5. development of a differential diagnosis

6. direct measures of attention, vigilance, or executive functions

7. appropriate psychological, educational, speech/language or other assessments indicated by the review of the above

The evaluation must be done by a multidisciplinary team including parents, teachers, physicians, school personnel and mental health personnel as well as other personnel as needed such as occupational therapists (OTs), physical therapists (PTs), speech/language pathologists. In the process of the evaluation, it is essential that associated co-morbidities be ruled in or out, as well as other underlying causes of the student's perceived difficulty with attention, concentration, disinhibition, and impulsivity identified.

Sufficient historical, behavioral, cognitive and medical data must be collected to identify the contribution, if any, of the following:

- Mental retardation
- Specific learning disability or learning weaknesses
- Psychological problems such as depression, anxiety disorder, conduct disorders, pervasive developmental disorders and obsessive compulsive disorder/obsessive compulsive behavior
- Substance abuse
- Sleep apnea or other sleep disorders
- In utero exposure to toxins such as alcohol or cocaine
- Exposure to environmental toxins such as lead, smoke
- Exposure to infectious agents such as Group A streptococcus, Borellia burgdorfiae (the cause of Lyme Disease), mycoplasma pneumonia
- Medical or neurological disorders such as seizure disorders, traumatic, brain injury, pre or perinatal injuries
- Gilles de la Tourette syndrome or other tic disorders

Evaluation Plan

I. Structured family interview

Purpose: To acquire a developmental and family history and assist in making a differential diagnosis, particularly in ruling out emotional and/or adjustment problems as well as medical factors

Format: Structured interview form such as used by school social workers or school psychologists found at multidisciplinary centers.

Provider: Specially trained personnel and parent.

II. Standardized behavior rating scales

Home and school versions should be completed and assessed for scores falling at or above statistically significant levels.

Purpose: See stated purpose of each scale

Format: Commercially obtainable scales

There are three kinds of scales:

1. broad based scales (i.e.,Achenbach's Child Behavior Checklist; Teacher and Youth Report Forms; Early Childhood, Child, Adolescent and Youth Symptom Inventories-4)

2. specific scales for ADHD (i.e., Child Attention Profile; Connors Parent and Teacher Questionnaires; ADHD Scales from the Stony Brook Early Childhood, Child, Adolescent and Youth Symptom Inventories-4; ACTeRS)

3. scales related to academic processing (i.e., Levine's ANSER)

Provider: Specially trained personnel, parent, teacher, and child, as scale designates.

III. Medical Examination

Neurodevelopmental assessment which includes appropriate physical and neurological exams. The purpose of this exam is to evaluate the student in comparison to peers the physician has previously seen as well as to published norms (Denckla, 1984). Assessing "soft" or subtle signs of neuromaturational immaturity will not make a diagnosis of ADHD, but can be supportive of the diagnosis and need for further services (OT, PT, etc.) In addition, the medical provider would decide if additional medical testing (thyroid screening, serological evidence of preceding infections, MRI, CT, EEG etc.) is recommended. Specific orders to carry out these tests require parental consent and may need to be agreed to and ordered by the child's primary care provider in order to be covered by the child's health insurance.

Purpose: To review the student's and family's history and make sure symptoms are not secondary to a medically remediable cause. It also provides a semistructured setting in which to observe the student for specific behavioral characteristics. The role of the medical pro-

vider is to identify any remediable causes, participate in the multidisciplinary evaluation and supervise medical intervention.

Format: A thorough history of the presenting problem, family and student's medical history, and a general physical examination including sensory testing if not recently assessed. The extended neurological examination (Paness, Denkla, 1984) gives a standardized way to evaluate each student with normative data for students 5-12 This one half hour exam gives the physician objective data on the student's ability to follow directions, ability to listen, a measure of the student's level of disinhibition and ability to inhibit responses. Since one of the sites in which the student may exhibit ADHD symptoms is the physician's office, using a structured exam can be most helpful.

The medical history should include review of systems and the following:

- Family history of ADHD symptoms, learning disabilities, other emotional/ behavioral problems
- Prenatal and perinatal events
- Allergy to medications, other allergies
- Developmental and medical history
- History of exposures to substances of abuse, lead, alcohol, smoke, pesticides, etc,
- Current health status, including changes in weight and/or height
- Sleep issues to identify sleep apnea or other sleep disorders
- History of medication exposure including current use of medication to treat chronic illness (i.e., Ventolin for asthma)
- History of prior documented infections such as (Group A streptococcus, Lyme Disease, mycoplasma pneumonia, or a history of meningitis or encephalitis)
- History of head trauma from sports injuries, prior abuse, vehicle accident

The physical exam should include the following if not done within the last year:

- Measurement of height weight, and head circumference plotted on standardized graphs
- Screening of hearing and vision, baseline blood pressure and heart rate

The medical evaluation is an essential part of the total evaluation but is only a part of it. The diagnosis of ADHD is dependent on the parent and teacher reports, psychological testing, educational assessment and mental health information.

The medical exam can add structured observation information. Observation of a student's behavior in the waiting room should focus on the following: ability to interact with other children, use of toys, ability to sustain an activity, movement from activity to activity, and cooperation with parent or office staff. Once in the physician's office, it is sometimes useful to see the student alone or with staff without parent if one notices much parent/ child conflict. Whether or not the student related age appropriately with the physician provides important information and tells something about the student's relationships with adults. The sex of the medical provider may also be of significance. By carrying out the structured extended neurological exam

with a wide range of children, the examiner develops a feel for children who carry out the tasks in an atypical manner, for example with excess gusto, beating instead of patting, hopping in circles instead of in place, talking incessently, or pushing aggressively.

Provider: Physician or physician extender – Physician's Assistant (PA) or Certified Pediatric Nurse Practitioner (CPNP)

IV. Systematic Formal Behavioral Observation

Purpose: To compare student's behavior with other students in a school-or in a clinic setting.

Format: Structured behavioral observation forms such as found in ADHD School Observation Code (ADHD - SOC)

(Commercially available scale from Checkmate PLUS P.O. Box 696, Stony Brook, NY 11790-0696)

Provider*:* Specially trained personnel

V. Assessment of Areas of Competence/ Deficits

Purpose: To obtain direct evidence of student's strengths and weaknesses in some or all of the following areas:

Cognition
Memory
Language
Visual/spatial ability
Academic performance
Social/emotional ability
Attention, vigilance, executive functions

Format: Commercially available psychometric instruments (i.e., Wechsler Intelligence Scale for Children – Revised [WISC-III], Wide Range Assessment of Memory and Learning [WRAML], Conner Computerized Performance Test [CPT], etc.)

Provider: Specially trained personnel

CHAPTER 5

INTRODUCTION
Legal Issues Affecting Decision Making for Students with Attentional Disorders: an Overview of the Statutes and Regulations

In addition to applicable State laws and regulations, there exist three Federal statutes and implementing regulations which address the educational needs of children with disabilities, including children with attentional disorders: The Individuals with Disabilities Act, Section 504 of the Rehabilitation Act and the Americans with Disabilities Act.

IDEA 1997
20 U.S.C. Chapter 33, Sec. 1400, 34 C.F.R. 300.

The Individuals with Disabilities Education Act (I.D.E.A.) has since its passage in 1975 and effective date of 1977, provided for the creation of a free appropriate public education for children with disabilities in need of special education and related services. When the "Act" was reauthorized most recently in 1997, Congress included "attention deficit disorder" (ADD) and "attention deficit hyperactivity disorder" (ADHD) as possible conditions associated with the qualifying disability category known as

"other health impairment".

To be entitled to special education services under I.D.E.A., a child, birth to 21 years of age, must have a disability condition specifically recognized under the I.D.E.A. and be in need of special education and related services. Children with attentional disorders may be, but are not automatically eligible for special education services under I.D.E.A. The determining factors that must be met are:

1) does the child have a recognized disability covered by I.D.E.A.; and
2) does the disability adversely affect the child's educational performance such that the child requires special education and related services.

If both of these factors are met, the child is eligible for special education and related services.

Section 504
29 U.S.C.A. Sec. 706 & 794, 34 C.F.R. Sec. 104

Section 504 refers to that section of the Rehabilitation Act of 1973 (effective date 1977) that is a broad civil rights law aimed at ending discrimination by any program or entity that benefits from federal financial assistance. To qualify as having a disability under Section 504, an individual must have a physical or mental condition that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

ADD and/or ADHD may satisfy as a disability condition under Section 504, depending on the severity of the resulting disability condition. If a student is determined to be protected by Section 504, then he/she may have a §504 Plan which identifies reasonable accommodations, modifications, special education, and related services to meet his/her educational needs.

A.D.A.
42 U.S.C. 1210

Like Section 504, the Americans with Disabilities Act of 1990, was passed to additionally prohibit discrimination against individuals with disabilities. Title II of the Act prohibits discrimination against individuals with disabilities in public schools. Title III of the Act prohibits discrimination against individuals with disabilities in the private sector, with certain limitations.

Unlike Section 504 of the Rehabilitation Act of 1973, the ADA does not make particular mention regarding how children with disabilities receive educational services. For this reason, the I.D.E.A. and Section 504 continue to provide the legal parameters that define how children with disabilities, including children with attentional disorders, receive educational services.

State Laws

Rhode Island General Law at Title 42, Chapter 87 provides parallel protections under State law as those guaranteed under Section 504 of the Rehabilitation Act of 1973 and the Americans With Disabilities Act.

Rhode Island also has incorporated the entitlements of the I.D.E.A. into the Regulations Gov-

erning the Special Education of Students with Disabilities.

Both of these laws and regulations have implications for the education of eligible children with attentional disorders.

Children with Attentional Disorders

I.D.E.A.
(and State Special Education Regulations)

Children with attentional disorders may be eligible for special education under I.D.E.A. and entitled to an Individualized Education Program (IEP) if they meet a criteria of disability, one of which may include "other health impaired", and be in need of special education and related services. The decision of eligibility must be made by a team of qualified persons and the parent. The need for special education and related services must be made on an individualized basis in accordance with an IEP.

Section 504/ADA

Children with a physical or mental impairment that substantially limits one or more of their major life activities, (have a record of, or are regarded as having such an impairment) are entitled to a free appropriate public education under Section 504 and/or the ADA. Typically under Section 504, a plan is developed to provide accommodations and/or modifications to the program or services offered by a provider of education. The accommodations/ modifications must be determined on an individual basis.

The Evaluation Process

A child with a suspected disability covered under I.D.E.A. may be referred for an evaluation by contacting the designated employee of the district to act on referrals. Check with the school principal or Special Education Director to determine where the referral should be sent. Similarly, a child with a suspected disability covered under Section 504 can be referred for an evaluation by contacting the designated employee of the district (Section 504 coordinator) or school principal. If an evaluation team determines the child is eligible for services under I.D.E.A., an IEP team will develop an IEP for the child. If the child is determined to have a disability covered by Section 504, a 504 Service Plan will be developed.

It is important to note that parental suspicion or a medical diagnosis of attentional disorder alone does not automatically require an evaluation. However, such factors in combination with concerns shared by school personnel that the child needs modifications to regular education services or needs special education services do require the school department to pursue an evaluation of the child to determine whether a disability exists and if so, what services will meet the child's identified educational needs. If the school department does not pursue an evaluation based upon a parental referral, notice of the due process right to appeal that decision must be provided to the parent(s).

APPENDIX A

Diagnostic criteria for
Attention-Deficit/Hyperactivity Disorder

A. Either 1 or 2:

1. six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

a. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities

b. often has difficulty sustaining attention in tasks or play activities

c. often does not seem to listen when spoken to directly

d. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)

e. often has difficulty organizing tasks and activities

f. often avoids, dislikes, or is reluctant to engage in

tasks that require sustained mental effort (such as schoolwork or homework)

g. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)

h. is often easily distracted by extraneous stimuli

i. is often forgetful in daily activities

2. six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

a. often fidgets with hands or feet or squirms in seat

b. often leaves seat in classroom or in other situations in which remaining seated is expected

c. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

d. often has difficulty playing or engaging in leisure activities quietly

e. is often "on the go" or often acts as if "driven by a motor"

f. often talks excessively

Impulsivity

g. often blurts out answers before questions have been completed

h. often has difficulty awaiting turn

i. often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

***Code* based on type:**

Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months

Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months

Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months

Coding note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified.

Source: American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, 4th Edition. Washington, DC: Author.

APPENDIX B

RESOURCES

ORGANIZATIONS/SUPPORT GROUPS

CHADD – Children and Adults with Attention-Deficit/ Hyperactivity Disorder

Local: CHADD of Rhode Island 810
PO Box 8251, Cranston, RI 02920, Tel: 401 943-9399,
ChaddofRI810@aol.com

National:CHADD
8181 Professional Place, Suite 201, Landover,MD 20785, Tel 800 233-4050, http://www.chadd.org

Attention Deficit Disorder Association (ADDA)
PO Box 972, Mentor ,OH 44060, Tel: 888 265-8711

Learning Disabilities Association of America (LDA)
4156 Library Road, Pittsburgh, PA 15234, Tel: 412 341-1515

RIPIN – RI Parent Information Network
500 Prospect St., Pawtucket, RI 02860, Tel: 727-4144

INTERNET RESOURCES

ADD and ADHD Infoline: http://www.alcasoft.corn/add
Information and resources put together by a family's personal experience with ADD.

ADHD News.Com: http://www.adhdnews.corn
An ADHD Newsstand – provides free newsletters – "Added Attractions."

ADD Webnet (AOL): http://members.aol.com/addwebney/index.html
A central directory of links that connects you to sites of individuals or groups that provide information, offer support, or share insights on ADD.

One ADD Place: http://www.oneaddplace.corn
A "virtual neighborhood" that consolidates information and resources.

Understanding the Child with ADHD. *The American Academy of Pediatrics*. 1999.
http://www.aap.org/family//adhd.htm

NIH ADHD Information site (in English and Spanish).
http://www.nimh.nih.gov/publicat/adhd.htm#adhd3

NICHCY – National Information Center for Children and Youth with Disabilities
http://www.nichcy.org
has information and resources relating to all disability categories.

VIDEOS

Barkley, R. (1992). *ADHD – What Can We Do?* New York: Guilford Press.

Biederman, J., Spencer, T. & Wilens, T. (1997). *Medical Management of Attention Deficit Hyperactivity Disorder – Parts I and II.* Plantation, FL: Specialty Press.

Rief, S. (1993). *ADHD Inclusive Instruction and Collaborative Practice. New York:* National Professional Resources.

The ADD Warehouse: www.addwarehouse.com
has numerous videos and provides a brief explanation of each one

CATALOG

ADD Warehouse
300 Northwest 70th Ave. Suite 102, Plantation, FL 33317, Tel 800 233-9273
http://www.addwarehouse.com

APPENDIX C

SELECTED REFERENCES

Abikoff, H.B. & Klein, R.G. (1992). "Attention-Deficit Hyperactivity Disorder and Conduct Disorder: Comorbidity and Implications for Treatment." *Journal of Consulting and Clinical Psychology,* 60, 881 – 892.

Alexander-Roberts, C. (1994). *The ADHD Parenting Handbook.* Dallas, TX: Taylor Publishing.

Alexander-Roberts, C. (1995). *ADHD and Teens: A Parent's Guide to Making it Through the Tough Years*. Dallas, TX: Taylor Publishing.

Amen, A.J., Johnson, S. & Amen, D.G. (1996). *A Teenager's Guide to ADD: Understanding and Treating Attention Deficit Disorder Through the Teenage Years.* Fairfield, CA: MindWorks Press.

American Medical Association (June 1997). *Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder in School-Age Children*. Scientific Affairs, pp. 418-432.

Anderson, W., Chitwood, S. & Hayden, D. (1990). *Negotiating the Special Education Maze: A Guide for Parents and Teachers.* Rockville, MD: Woodbine House.

Barkley, Russell A., *Attention-Deficit Hyperactivity Disorder: A Clinical Workbook*, New York: Guilford Publications, Inc., 72

Spring Street, New York, NY 10012; 1-800-365-7006/Fax: 212-966-6708. A collection of diagnostic and assessment tools including rating scales, report forms, etc.

Barkley, R. (1987). *Defiant Children: A Clinician's Manual for Parent Training*, New York, Guilford Publications, Inc., 72 Spring Street, New York, NY 10012; 1-800-365-7006 /Fax: 212-966-6708

Barkley, R. (1997). *ADHD and the nature of self-control*. New York: Guilford Press.

Barkley, R. (1998). *Attention Deficit Hyperactivity Disorders: A Handbook for Diagnosis and Treatment*. New York, Guilford Press.

Bash, M. S., & Camp, B. (1985). *Think Aloud: Increasing Social and Cognitive Skills - A Problem Solving Program for Children*. Champaign, IL: Research Press.

Biederman, J. (1998). *Attention-Deficit / Hyperactivity Disorder: A Life-Span Perspective*. Journal of Clinical Psychiatry 59 (Supplement 7): 4-16.

Biederman, J. et al. (1999). *Pharmacotherapy of Attention-Deficit / Hyperactivity Disorder Reduces Risk for Substance Use Disorder.* Pediatrics 104:e20.

Bloomquist, Michael L., *A Parent's Skills Training Guide for Children with Attention Deficits and Disruptive Behavior*, Minneapolis Department of Professional Development and Conference Services, University of Minnesota, 207 Nolte Center, 315 Pillsbury Drive, S.E., Minneapolis, MN, 55455.

Braswell L., Bloomquist, M. and Pederson, S. (1991). *ADHD: A Guide to Understanding and Helping Children with Attention Deficit Hyperactivity Disorder in School Settings*. Minneapolis Department of Professional Development and Conference Services, University of Minnesota, 207 Nolte Center, 315 Pillsbury Drive, S.E., Minneapolis, MN, 55455.

Brown, T. E. (2000). *Emerging understandings of attention-deficit disorders and comorbidities*. In T. E. Brown (Ed.), Attention-deficit disorders and comorbidities in children, adolescents and adults (pp. 3-55) Washington, D.C.: American Psychiatric Press.

Cantwell, D., Baker, L. (1992). *Attention Deficit Disorder with and without Hyperactivity: A Review and Comparison of Matched Groups*. J Am Acad Child Adolesc Psychiatry, 31:432-438.

Colemann, W. (1993). *Attention Deficit Disorders, Hyperactivity and Associated Disorders: A Handbook for Parents & Professionals,* 6th Ed. Madison, WI: Calliope Books.

Conners, Keith C. and Jett, J. L. (1999). *Attention Deficit Hyperactivity Disorder*. Kansas City, Missouri: Compact Clinicals.

Copeland, E., and Love, V. (1993). *Attention, Please! A Comprehensive Guide for Successfully Parenting Children with Attentional Disorders and Hyperactivity*. Hawthorne Educational Services, Inc., 800 Grey Oak Drive, Columbia, Missouri 65201; 1-800-542-1673.

Copeland, E. (1991). *Medications for Attention Disorders (ADHD / ADD) and Related Medical Problems*. Atlanta, Georgia: SPI Press.

Flick, Grad L. (2000). *Managing Teens with ADHD*. West Nyack, NY: The Center for Applied Research in Education.

Goldman, L., et al (1998). *Diagnosis and Treatment of Attention-Deficit / Hyperactivity Disorder in Children and Adolescents*. Journal of the American Medical Association: 279: 1100-1107.

Goldstein, S. (1999). *The Facts about ADHD: An Overview of Attention-Deficit Hyperactivity Disorder*. CHADD 1999 Conference Book. Landover, MD: CHADD.

Goldstein, S. & Goldstein, M. (1992). *Hyperactivity: Why Won't My Child Pay Attention.* New York: Wiley-Interscience.

Goldstein, S. & Mathers, N. (1998). *Overcoming Underachievement: An Action Guide to Helping Your Child Succeed in School.* New York: John Wiley & Sons.

Greenberg, G. & Horn, W. (1991). *Attention Deficit Hyperactivity Disorder: Questions and Answers for Parents.* Champaign, IL: Research Press.

Hart, E.L., Lahey, B.B., Loeber, R., Applegate, B., Frick, P.J. (1995). *Developmental Change in Attention-Deficit Hyperactivity Disorder in Boys: A Four Year Longitudinal Study*. Journal of Abnormal Child Psychology, 23: 729-749.

Hechunan, L., Ed. (1996). *Do They Grow Out of It? Long-Term Outcomes of Childhood Disorders*. Washington, DC: American Psychiatric Association.

Hinshaw, Stephen P. (1999). *Moderators and Mediators of Treatment Response for Children with Attention Deficit / Hyperactivity Disorder*. Archives of General Psychiatry; 56:1088-1096.

Lambert, N.M. (1988). *Adolescent Outcomes for Hyperactive Children*. American Psychologist, 43, 786-799.

Nadeau, K.G., Dixon, E.B. & Biggs, S.H. (1995). *Schools' Strategies for ADD Teens.* Annandale, MD: Chesapeake Psychological Publications.

Parker, H.C. (1988). *The Attention Deficit Disorder Workbook for Parents, Teachers and Kids*. Plantation, FL: Impact Publications.

Parker, H. (1992). *The ADD Hyperactivity Handbook for Schools*. Plantation,FL: Impact Publications.

Parker, H. (1992). *ADAPT: Attention Deficit Accommodation Plan for Teaching.* Plantation,FL: Specialty Press.

Pliszka, S.R. (1998). *Comorbidity of Attention-Deficit / Hyperactivity Disorder with Psychiatric Disorder: An Overview*. Journal of Clinical Psychiatry 59 (Supplement 7): 50-58.

Robin, A. (1998). *ADHD in Adolescents.* New York: Guilford Press.

Stony Brook Early Childhood, Child, Adolescent and Youth Symptom Inventories – 4, Checkmate Plus, PO Box 696, Stony Brook, NY 11790-0696.

Wachtel, A. (1998). *The Attention Deficit Answer Book*. New York: Plume (Penguin).

Weiss, M. & Jain, U. (2001). *Clinical perspectives on the assessment of ADHD in adolescence*. In R. Barkley (Ed.), The ADHD Report. New York: Guilford Press.

Zeigler Dendy, Chris A. (1995). *Teenagers with ADD – A Parent's Guide*. Bethesda, MD: Woodbine House.